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(Editors)

Sources and Traditions of Classification in Psychiatry

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Preface

With regard to psychiatric classification and nomenclature all mental health workers should be bilingual: They should command both an international terminology and their own national or local professional language.

The latter is necessary for the description of phenomena relevant to psychiatric work in the specific culture, which may influence diseases and create conditions seen nowhere else. In addition, the local language may comprise words that can describe some psychiatric states with greater precision than can be obtained by means of words contained in other languages. Psychiatry is a field of considerable difficulty, and speaking about psychiatric problems demands delicate use of all resources of the language one knows best. Yet, to convey one's findings to others, an international professional language is necessary for psychiatry as well as for all other medical disciplines. Unfortunately, it is the fate of such international terminologies and classifications that they become subjects of criticism and cause severe dissatisfaction. Nobody can identify fully with them; concepts that seem necessary for many are lacking, and unfamiliar terms are introduced. These new concepts also cause anger: Why should *that* school be allowed to have some of its favorite concepts accepted, while some of *our* most useful terms are refused admittance?

In this situation the best remedy is to improve understanding of the conceptual worlds of other psychiatric schools and of the historical origin of their concepts and terms. The present volume provides the bases for such understanding. As well, the historical accounts given offer exciting reading.

Thus, for instance, the extremely complex origin of the Spanish culture in general and Spanish medicine in particular, has made it natural for J. J. López-Ibor to follow the roots of Spanish psychiatry—Arab, Greek, Roman—back to antiquity. In contrast, A. V. Snezhnevsky shows how a new classification and terminology of the major psychoses has developed within Russian psychiatry during a few decades, based on detailed studies of course and symptomatology.

For non-Francophone psychiatrists who have looked upon French psychiatry with great respect but a minimum of understanding, P. Pichot's chapter will be much welcomed for help. German psychiatry has had great impact on all other psychiatric schools, especially through its description of the endogenous psychoses: J. Glatzel's account shows how much German psychiatry has contributed in many other directions.

An overview of psychiatric literature during the 1980s might give the impression that American psychiatric thinking is mainly concentrated on DSM-III. G. Klerman's chapter gives abundant evidence to the contrary, showing how versatile American psychiatry has been over the years—and still is.

R. E. Kendell's account of English psychiatry illustrates, among other things, the great importance British research has had for the establishment for a solid foundation of international classifications.

In P. Bech's chapter, an account is given of the important position the psychogenic (reactive) psychoses have held in the Scandinavian countries since the beginning of this century.

N. Wig provides overwhelming evidence for the importance of including concepts which are indispensable for work in developing countries into any international classification.

The rich and interesting material presented in this volume will undoubtedly lead to more benevolent, understanding attitudes toward the difficult attempts at creating international psychiatric classifications. This is of particular importance now that the 10th Revision of the International Classification of Diseases is about to enter into worldwide long-lasting use.

Erik Strömgren

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Editors' Foreword

In the early 1960s, the World Health Organization initiated a major international program in order to stimulate research leading to an improvement of psychiatric diagnosis and to standardize strategies about mental disorders. The program brought together experts in psychiatry and public health specialists from some 30 countries and produced several important results over the years. It has facilitated the dialogue among representatives of psychiatric schools, and between them and public health specialists. It has developed, adapted or tested in an international setting joint ratings of videotaped interviews and other methods for the study of diagnosis in psychiatry. It has produced numerous proposals for the improvement of the classification of mental disorders, among which was the inclusion of a glossary describing the content of each of the categories grouping mental disorders into the 8th Revision of the International Classification of Diseases. A network of individuals and centers working on matters concerned with psychiatric disease classification was established [1, 2] and continued its existence.

The next decade saw continuing growth of interest in psychiatric classification, perhaps in part stimulated by WHO's efforts, but certainly fueled by the burgeoning of research on new methods of treatment and by the growing number of contacts between psychiatrists worldwide. International travel became easier, psychiatric conferences mushroomed, and several international collaborative studies opened the doors to other worlds of psychiatry even further. Several national classifications accompanied by criteria of varying precision were produced, aiming to facilitate understanding among scientists. Among these the efforts of the American Psychiatric Association embodied in the DSM III did the most to bring about a general acceptance of the need for agreed (operational) criteria and a comprehensive classification that can be used for various tasks within psychiatry.

In the late 1970s, the World Health Organization, in collaboration with the US Alcohol, Drug Abuse and Mental Health Administration, established an international program on classification and diagnosis of mental disorders, alcohol and drug-related problems [3]. This program started with a series of workshops in which groups of scientists representing different psychiatric traditions and cultures met to review available knowledge and identify areas for future research. The findings and recommendations of the working groups were reviewed in a major international conference [4], resulting in material and guidelines for future work.

Several of the recommendations of the conference led to major research projects. A project involving centers in 17 countries was started

to develop an instrument suitable for epidemiological studies of mental disorders in different countries [5]. Another collaborative study was launched to develop an instrument for the assessment of the mental state by clinicians [6]; and yet another also involving centers in many countries to develop an internationally applicable personality disorder examination [7]. A series of Lexicons systematically providing definitions for terms used in the 9th and 10th Revisions of the International Classification of Diseases, as well as numerous other terms, is being published [8]. While these projects were getting underway, the task of producing definitions of criteria for use in conjunction with the 10th revision of the ICD became imminent. The synchrony of work on instruments and on criteria for the ICD proved to be beneficial: The development of instruments helped in operationalizing criteria for the ICD and vice versa—the discussions about the classification found their reflections in the shape and content of the assessment instruments.

Another one of the recommendations of the Copenhagen conference was that the views of different psychiatric schools should be presented in a (single) volume to facilitate the understanding of origins of the classification proposed for international use from 1990 onwards. It was with this goal in mind that the Steering Committee of the joint WHO/ADAMHA project has assembled the views of most major psychiatric schools (or groups of schools) and presents them in this publication to the world's scientific community. The papers brought together in this volume have been prepared by leading authorities thoroughly conversant with their respective subject. As a result, the various chapters present a panorama of psychiatric thinking over time in different sociocultural settings. The papers highlight the origins of concepts, some of which have gained wide currency in contemporary psychiatry, while others have given rise to critical debate. They demonstrate both similarities in approach or philosophy and still existent differences. A number of them are already bridged in practice, and others can probably be overcome, too. But there is little hope that progress toward creating a language all concerned can understand will be made until all those involved listen very carefully to what the others are saying. It is the editors' hope that this book should make it easier to do so.

There is no doubt about the need to continue work that will eventually lead to diagnostic criteria linked to internationally applicable and acceptable instruments for psychiatric assessment and to standardized and largely automated information systems which will make it possible to plan, evaluate and steer psychiatric services or carry out epidemiological, biological and other research on mental illness.

Once this effort of description and processing of information is further advanced, it is likely that differences between psychiatric schools

will become less noticeable and less easy to maintain. This will not make the descriptions of views of the schools presented here epistemologically and historically less valuable. On the contrary, they will gain in importance because they will continue to remind us that much that was achieved could only be reached because of the contributions, over the years, of many people and in many lands of this one world.

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1

Sources and Traditions of Psychiatric Classification: Introduction

Norman Sartorius*

A classification is a way of seeing the world. It is the reification of an ideological position, of an accepted standard of theory and knowledge. Classifying means creating, defining or confirming boundaries of concepts. Through these, in turn, we define ourselves, our future and our past, the territory of our discipline, its importance and its exclusiveness. No other intellectual act is of such importance: If our classifications of things and people in the world around us were to collapse, the world would cease to exist as a coherent and organized whole and would become a nebulous agglomeration of rubbish—matter, people and things out of place.

Classifications of diseases in psychiatry were at the center of interest not only among psychiatrists but also among lawyers, philosophers, taxonomists and many others even before psychiatry as a medical discipline came into existence. In part this arose because the absence of physical signs and laboratory abnormalities in many psychiatric disorders makes psychiatric disorders much more dependent on the consensus of what in a given society is normal, what is abnormal, what is asocial and what is part of a disease. In part, also, the interest in psychiatric classification springs from the intermingling of understandable and incomprehensible behavior, from the frequency of psychiatric symptoms in the normal population and from the absence of specific treatments that would allow a classification *ex juvantibus*. Many of the conditions that could be the subjects of psychiatric classification are of unknown origin, have a variable course and an uncertain outcome; epistemologically, they have a low rank and present formidable difficulties for placement into a classification of diseases. In the absence of convincing evidence, some continue to consider psychiatric disorders to be similar to ailments in general medicine and thus eventually

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definable as diseases, with specific causes, symptoms, course and outcome; others—with just as much conviction—preach the view that psychiatric problems are responses that are not specific to causes and therefore not appropriate to a system that classifies disease entities.

In spite of its promise, so prominent in the 1960s, research during the past two decades failed to provide evidence that could help to create disease concepts and disease entities in psychiatry. Syndromes—such as schizophrenia or depression—are still widely used, and most attempts to create coherent links between clinical symptoms, specific causal factors, pathogenetic models and prognostic types have failed. The numerous findings that the neurosciences, relying on apparatus of ever-increasing sophistication, have produced about the functioning of the brain have not been accompanied by any significant advance in the understanding of ways in which structures or processes in the brain are translated into mental functioning, or on how brain relates to mind. In part this was because new methods of investigation appeared so rapidly that there was a delay in the accumulation of data necessary to define limits of normality for the findings of such investigation; in part, however, this was also because of the growing distance between the neuroscientists, clinicians and epistemologists.

Some of the previously held views also form an obstacle to agreement on a classification or to improving it. The continuing insistence, for example, on the mind-body dichotomy inherent in some of the classification systems which emerged in the 19th century is such a constraint. Discontinuous with earlier European views and at odds with philosophies of other cultures, this dichotomy was an expression of the reductionist tendencies of the industrial revolution and, at the time, was useful in furthering the understanding of diseases and research. Today, however, this is not so: Other ways of thinking about health and disease, mind and body, mental and physical, individual and social are needed if we are to formulate creative hypotheses and design investigations likely to result in breakthroughs in our knowledge about mental illness.

Furthermore, recent years brought with them a significant increase in the recognition of cultural constraints to agreement on diagnostic and classificatory systems. Most of these are well known and do not need enumeration. Some, however, are less obvious and therefore more difficult to tackle. Such, for example, is the difference between the ways in which time is conceptualized and used in the description of phenomena; such is also the difference between cultures in their tolerance for unresolved conflict and contradiction. Those who can or even prefer to maintain indeterminacy do not accept working with classifications requiring immediate final assignment to classes on the basis of incomplete information.

The improvement of communication with psychiatrists from Third World countries and an increase in respect for what they have to say has, among other results, brought out the unresolved issues in psychiatric classifications in the industrialized countries. One of those, for example, is the issue of classification of acute psychoses—the frequent, undifferentiated conditions with reasonably good prognosis which make up a large proportion of all emergency admissions to psychiatric facilities and which seem almost to fit descriptions of a variety of conditions, such as psychogenic psychoses, cycloid psychoses and reactive psychoses. Another issue is the classification of conditions with somatic presentation usually bypassing psychiatric services. Yet a further one is the personality disorders whose degree of abnormality is very dependent on prevailing sociocultural norms and on our views about the likelihood that personality traits can be changed in time or by intervention.

The organization of helping agencies and arrangements for care have in recent years led to a decrease in agreement on classification. The growing diversity of services, for example, and the increasing separation between systems that administer them led to the development of different "service languages." General health care personnel now deal with many mentally ill people and develop classifications they find easy to use. The growing complexity of health insurance accounting has led to a language and classification that is used and useful within that system, but that can be only partially linked to classifications used in health services. Classifications and language conventions for a variety of other purposes and for different social service sectors have mushroomed in many countries and serve well in practice. Unfortunately, the mushrooming of jargons and classification schemes has not been paralleled by efforts to ensure that they can be translated into a reference classification. As a result, in many settings the same condition changes labels as patients pass through health care, research and social welfare facilities, and any attempt to pool information from different systems becomes an expensive utopia. At the same time, the development of long-term care in a complex health and social service system has brought with it the need to produce classifications reflecting adequately the many characteristics and requirements of the individual entering the system. Multi-axial classification schemes have made a major contribution in this respect; but even where they are applied, significant unanswered public health and practical needs remain. The number of patients, for example, who have several impairments and diseases—all encodable on the same axis and all relevant to care and outcome—is constantly increasing because of longer life expectancy in general, better chances of survival and improved diagnostic possibilities; ways of classifying the multitude of problems in an individual,

particularly when these require interventions by different social sectors or medical disciplines, have not yet been developed.

Developments that have little to do with the changes in our understanding of psychiatric disorders have also had an impact on the classificatory scene. The support of the pharmaceutical industry for work on classification and the impact of requirements of drug regulatory agencies requesting investigators to specify the diagnostic system used in drug trials led to a striking increase of interest in psychiatric classification. On the other hand, recent difficulties in the use of psychiatric registers, resulting *inter alia* from the upsurge of interest in the rights of the mentally ill and the significant decentralization of data collection (for example, to the federal, state or even county level), decreased possibilities that data could be pooled; and the starvation budgets given to public health agencies in many industrial countries led to a sharp decrease of interest in work on classifications among public-health-oriented psychiatrists. Paradoxically, the leadership in classification research has thus shifted from psychiatrists with a main interest in public health to those engaged in treatment research.

In many countries, national societies have undertaken and completed revisions of their classification. The most spectacular of these is the classification proposed by the American Psychiatric Association (DSM-III, the DSM-III-R and the Research Diagnostic Criteria); but important developments have also appeared in many other settings ranging from the publication of the elaborate glossary of psychiatric syndromes for epidemiological research in the USSR to the child mental disorder classification and the operational criteria for psychosis in French-speaking countries and the Indonesian classification and glossary. While immensely interesting and advancing our knowledge, this upsurge in the creation of national classificatory systems is also puzzling: It is difficult to understand reasons for its occurrence.

Kraepelin's classification was not the only one in Germany at the time; it represented the views of a professional offered to his pupils and fellows in the country and elsewhere—as a hypothesis open for everyone's use. Nationalist feelings in the allegiance of psychiatric schools have the appearance of nationalist feelings in the political sphere some 100 years ago: The need for national identification has appeared at an unexpectedly late moment in the history of classification, research and practice. Financial gain that can be obtained by producing and copyrighting a classification only partially explains this development. The unprecedented rivalry between professions each feeling that it will be legitimized once it has its own classification of diseases may also be invoked in seeking causes for it.

These and other developments threatened to obliterate gains made in the 1960s in understanding among scientists, clinicians and decision

makers. This would have been a pity at any time, but in the early 1990s it is a major menace to further progress of scientific discovery and improvement of care worldwide. Technology of communication and computing now makes it possible to pool vast quantities of data and thus detect trends and regularities that have not been accessible to discovery or analysis ever before. Without a common language these technological advances cannot be employed. The heightened priority and visibility of mental health services requires an efficient system of monitoring its function; for without a common usage and understanding of terms such an evaluation is meaningless. The rapid development of treatment techniques requires their continuous assessment which is unthinkable without an agreement on diagnosis and assessment of change.

These considerations were among the reasons for launching a major project on diagnosis and classification in 1980. This international effort, sponsored jointly by WHO and ADAMHA, started with an intensive review of the present state of diagnosis and classification, identifying gaps in knowledge and defining priorities and methodological requirements for multicenter research to overcome them. It continued by the implementation of several major international studies, aiming to produce assessment instruments that will be applicable in different cultures, glossaries, classification proposals, and reviews of knowledge relevant to diagnosis and classification.

A number of results from this project are already available. Networks of centers in some 30 countries, for example, collaborate in the testing of several instruments suitable for cross-cultural application and allow a comprehensive and reliable assessment of the mental state of patients in different countries. Lexical descriptions for psychiatric terms have been developed on the basis of contributions from experts from around the world. Numerous consultations with creators of national psychiatric classifications seem to offer hope that these classificatory systems will be translatable into an international reference classification.

The experience obtained in the project so far is rich and allows more rational priority setting in research on diagnosis and classification. It also allows—combined with results of trials of the 10th Revision of the International Classification of Diseases currently in process in 195 centers in 55 countries—to define principles that should govern the shape and content of a classification offered for universal use. Such a system should:

1) be based on points of agreement among mental health professionals, and between them and other users of the classification;

2) be sufficiently simple and understandable to allow easy use by those who will deal with commonly encountered disorders;

3) at all times be a servant rather than a master of classifications in existence. It must not aim to oust, compete with or replace regional or local classifications, which often have valuable functions and are likely to be well adjusted to the situation in which they have come into existence;
4) be sufficiently well liked as a tool of information exchange to generate translations of national or special-purpose classifications into the reference classification;
5) be rather conservative and theoretically unenterprising so as to remain attractive or at least acceptable to a wide variety of people of different orientations and knowledge;
6) be stable and abide by the rule that changes can only be introduced when sufficient scientific data have become available to support the change and facilitate its acceptance;
7) take into account languages into or from which the classification will be translated;
8) preserve a certain amount of continuity between successive revisions, for economic and scientific reasons.

The development of a classification corresponding to these requirements is not an easy task; its realization requires numerous scientific health-political and organizational steps. An essential requirement, however, in this process—common to all the necessary steps—is to examine the positions and promises inherent in currently used classifications with respect and with a determination to use the best of available knowledge, regardless of its source.

4

The Contemporary American Scene: Diagnosis and Classification of Mental Disorders, Alcoholism and Drug Abuse

Gerald L. Klerman*

I. Introduction: Psychopathology Revitalized

This paper describes the current American psychiatric scene with regard to the diagnosis and classification of mental disorders, including alcoholism and drug abuse.

The Renaissance of Interest in Psychopathology in the 1970s

During the 1970s, American psychiatry experienced a major revival of interest in and attention to issues concerning psychopathology, diagnosis and nosology classification, culminating in the publication of the *Diagnostic and Statistical Manual III* and *III-R* (DSM-III, DSM-III-R) by the American Psychiatric Association (APA, 1980, 1987). Interest in psychopathology has continued through the 1980s.

Because mental disorders are multiple and their treatments diverse, the need for a highly differentiated diagnostic system becomes more important. As Spitzer (1978), who guided the development of DSM-III, has stated:

> The purpose of a classification of medical disorders is to identify those conditions which, because of their negative consequences implicitly have a call to action to the profession, the person with the condition, and society. The call to

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action on the part of the medical profession (and its allied professions) is to offer treatment for the condition or a means to prevent its development; or, if knowledge is lacking, to conduct appropriate research.

DSM-III incorporated a number of features derived from recent research and clinical experience, the most significant of which was the development of operational criteria for individual disorders—criteria based mainly on directly observable manifestations of psychopathology. Except for the organic conditions, these criteria are generally free of etiological assumptions. In addition, more refined definitions of psychiatric syndromes and delineation of subgroups within the syndromes have also been incorporated.

The renaissance of diagnostic and nosological activity in the United States was accompanied by a division over the balance of scientific and humanistic aspects—a dilemma that exists for all medicine: while the unit of scientific interest is the disorder (or illness), the unit of clinical practice is the individual patient. Put another way; medicine studies diseases, but treats patients (Klerman, 1977; Illich, 1976).

This tension has contributed to continuing controversy and criticism of psychiatric diagnosis. Practitioners have complained that existing classifications hinder clinical practice in at least two ways. First, diagnostic categories are inadequate for understanding the complexity of individual patients and for clinical decision making. For example, it is argued that in evaluating the need to hospitalize suicidal patients, in addition to knowing whether or not the patient is depressed or psychotic, it is also necessary to assess personality aspects, such as the patient's impulsivity or degree of self control, as well as to have an adequate understanding of that patient's life circumstances, particularly current stresses, family and income, and social supports. Second, clinicians have claimed that assigning patients to categories contributes to depersonalization and deindividualization of the doctor-patient relationship.

In response to these criticisms, the DSM-III and the DSM-III-R adopted a multiaxial system. This five-part system consists of

- clinical psychiatric syndromes entailing aspects and symptoms of chronicity and periodicity (Axis I);
- personality disorders of adults and development disorders of children and adolescents (Axis II);
- medical illness (Axis III);
- psychosocial stressors (Axis IV);
- and level of adaptive functioning (Axis V).

The first three Axes utilize categorical judgments, while the last two utilize dimensional rating (Mezzich, 1980).

The DSM-III has generated controversy both within the United States and between U.S. psychiatrists and those from other countries, many of whom follow the World Health Organization International Classification of Diseases (WHO-ICD; WHO, 1980; Skodal, 1982).

Purpose of This Paper

This paper examines the diversity of the contemporary American psychiatric scene against a background of some of the major forces—historical, social and scientific—that have shaped its activities, formed its theories and provided impetus for research and clinical advances. This examination begins with a conceptual perspective from which to view the diversity that characterizes U.S. psychiatry (Section II), followed by an overview of the historical contexts from which multiple schools of psychiatry emerged (Section III); post-World War II developments and advances leading to current emphases on empirical psychiatry are described. Section IV presents the origins, tenets and proponents of the major contemporary schools of American psychiatry, focusing particularly on their views of diagnostic and nosologic efforts. Section V addresses the approaches of the contemporary schools to selected mental disorders, with primary emphasis on research efforts. Section VI concludes with identification of future trends.

II. The Diversity of American Psychiatry

Early in the history of psychiatry in the United States, different emphases emerged for the study and treatment of mental disorders; the biological organism, mental processes (conscious and unconscious), the societal and institutional setting for care and socially adaptive behavior. While the dominance of these emphases has fluctuated at different times, they have provided the basis for the growth of multiple, competing schools, each of which, in turn, has developed its own theoretical, research, clinical and treatment framework.

It is important to recognize that, in the United States at the present time, no school is dominant. Currently, the American psychiatric profession has multiple scientific sources that draw on specialized knowledge within its own broad sphere, ranging from psychoanalysis to psychobiology, as well as on related disciplines of neurobiology, psychology and epidemiology. The diversity characterizing the American professional scene is manifested in considerable ferment and rivalry among the alternative schools. The extent of this diversity has been

described by Armor and Klerman (1968), Havens (1973) and Lazare (1979).

Observers of the American scene have cataloged the schools in various ways. In their influential study of social class and mental illness, Hollingshead and Redlich (1958) divided the practitioner community in New Haven into two groups which they referred to as "Analytic and Psychological" (A-P) and "Directive and Organic" (D-O); subsequent researchers employed other groupings. In the early 1960s, Strauss and associates in Chicago (Strauss et al., 1964), using sociological survey methods, and Armor and Klerman (1968), studying a nationwide sample of psychiatrists working in hospitals, identified three psychiatric schools: a biological (or organic) school, a psychological/psychodynamic school and an emerging social/psychiatric school.

Table 1 identifies the five schools most relevant, in this author's view, to the current American psychiatric research scene in regard to diagnosis and classification issues.

Table 1. Contemporary American schools of psychiatry.

—BIOLOGICAL
—PSYCHOANALYTIC
—SOCIAL
—INTERPERSONAL
—BEHAVIORAL

Observers of the American scene will note that a number of influential groups of mental health practitioners are not represented here. For example, the existential school, identified and described by Havens (1973), while influencing many modern philosophers and writers by extending tenets of existential philosophy and literature into therapeutic theory, has had relatively little impact on psychiatric research or practice. Similarly, new forms of psychotherapy, such as Gestalt therapy, humanistic psychology and transactional analysis, that have proliferated in the last decades, particularly among nonmedical practitioners, have often been critical of the psychiatric "medical model" and modes of diagnosis and classification.

The community mental health movement also does not appear here as a separate school; rather, it is regarded as an application of social psychiatry. While it has effected major changes in the delivery of mental health services, its adherents have tended to ignore issues of diagnosis and classification in both their writings and clinical practice. The theoreticians and practitioners of community mental health have

in fact, at times critical of the medical model and have often been allied on an antidiagnostic position with the antipsychiatry movement.

Ideological Aspects of Schools of Psychiatry

Reference to "schools" of psychiatry in the United States focuses on internal divisions reflecting the different beliefs and cognitive views and practices within the profession. However, it is readily apparent that the ideas and views of these various "schools" are strongly held by their proponents, so much so that discussion of scientific and professional issues among psychiatrists is often attended by dispute, dissension and acrimony. The sociological concept of ideology is useful to describe the complexity of the American psychiatric scene more specifically.

Although most prominently explored and applied in the fields of social, economic and especially political theory (Mannheim, 1936), the concept of ideology has been useful in understanding the processes of cohesion and fragmentation in professions (Strauss et al., 1964; Armor & Klerman, 1968). In the field of psychiatry, a professional ideology may be said to consist of four components: cognitive, descriptive or normative, emotive, and social and affiliative.

Psychiatric schools often become "movements," involving not only the members of the profession, but intellectuals, journalists, legislators and others outside the profession allied with a school's particular views. Thus, we identify a "psychoanalytic movement" or a "community mental health movement," whereas, in other branches of medicine we would seldom, if ever, refer to a "surgical movement" or an "epidemiological movement."

The schools of American psychiatry have differed strongly as to their concepts of mental illness as well as to specific aspects of diagnostic reliability, validity and appropriateness. The differences among the schools also extend to social and ethical issues. Some schools, for example, regard diagnostic efforts as depersonalizing and antitherapeutic and, at times, politically repressive. The force of these ideological elements has often influenced efforts at revision of diagnostic nomenclatures, as witnessed by some of the debates and controversies attendant upon the creation and promulgation of DSM-III and DSM-III-R. My conclusion is that contemporary psychiatry in the United States involves multiple, competing paradigms. It may be that one paradigm will emerge as dominant in the future.

III. The Historical Background

Since its inception and particularly after World War II, multiple schools have developed. This section describes briefly the historical and social forces leading to the differentiation of competing schools after World War II.

The 18th and 19th Centuries

As Foucault (1965) pointed out, the conception of mental disturbances as "illness" was a creation of Enlightenment thinking of the late 18th century. It is not that insane persons or public institutions for their care did not exist before this time; rather, the needs of the mentally ill had been seen until this time as the sole responsibility of law-enforcement agencies or of the church—not of medical specialists and public health administrators. This movement parallels the birth of psychiatry under the leadership of Pinel, who became the first *medical* superintendent of Salpetriere. Salpetriere—involved in the production of saltpeter in the 17th century—was converted first into a hospital for indigents and a few years later into an asylum for madwomen. After a century under political supervision, Pinel, in 1795, unchained the insane and treated them as mentally ill—not as "animals."

The notion of "medical illness" was part of the rational, naturalistic approach to human behavior of Enlightenment thinking. Thus, at the beginning of the American Republic, treatment of the mentally ill was optimistic, reflecting the confidence of the new nation, particularly embodied in the important influence of Benjamin Rush, a signer of the Declaration of Independence and the first American physician to write about mental illness (Musto, 1973).

Psychiatry became a medical specialty in the U.S. in the 1840s with the creation of the Association of Medical Superintendents of Institutions for the Mentally Ill. The dominant approach held by these medical superintendents was known as "moral treatment" (Bockoven, 1963; Rothman, 1971; Grob, 1973). Modeled on the innovative efforts of Pinel in Paris, France, and the Duke of York in England, moral treatment was based on the humanitarian values of the Enlightenment, with emphasis on work and planned activities for patients in a restful, respectful and properly administered environment. The moral treatment of the 19th century provided an antecedent for the mental hygiene movement of the early 20th century and the community mental health movement of the 1960s.

Moral treatment was based on a social approach to treatment of mental illness, legitimizing the authority of the medical superintendent

to structure that "moral" environment. In the 1950s, this focus on the hospital environment was evident in the treatment approach known as the "milieu therapy." During both historical periods—the "moral treatment" era of the mid-19th century and the "milieu therapy" era of the 1950s—the attempt was to create an institutional environment that could support and encourage the rationality of patients and their inherent capacity to recover.

In the second half of the 19th century, the moral treatment movement declined in vigor and fell into disrepute. Mental hospitals became overcrowded and increasingly custodial. Various explanations have been given for these changes. Bockoven (1963) attributes much of the decline to the adverse consequences of increasing numbers of Irish, Italian and German immigrants, who overwhelmed and overtaxed public agencies, and the concomitant antipathy of the dominant population to expend monies for services to these "alien" populations. Rothman (1971) also notes the change in demographic character of the patients for which moral treatment had originally been intended. In addition to large immigrant populations, ever-increasing numbers of asylum patients were chronically medically ill and senile, which heightened the tendency toward custodial rather than therapeutic efforts.

The decline in moral treatment was associated with growth of biological theories. Social Darwinism flourished, mental illness was regarded as the inevitable result of "degenerative" process—a view that led to pessimism among professionals, justified "benign" neglect, and shifted emphasis from the therapeutic potential of hospitals to custodialism. In scientific areas, social Darwinism led to a strong interest in the new advances in biology. Activities in bacteriology and pathology derived from French and German laboratories were increasing. These new fields did not, however, have full impact on American psychiatry until after the reforms of American medical schools brought about after the Flexner Report in the early 20th century. At the end of the 19th century, the intellectual and scientific stature of American psychiatry had seriously declined. Its intellectual impoverishment and low professional self-esteem during this period have been described by Hale (1971), Rothman (1980) and other historians.

Until the early part of the 20th century, psychiatry in America, as in most of Western Europe and North America, was almost exclusively practiced in hospital settings. Only a very small number of psychiatrists were in private practice, although many neurologists and other physicians saw psychiatrically ill patients in their office practice. The main concern of psychiatrists was with those disorders that today would be diagnosed as psychotic. Description of various forms of psychoses by Pinel and Esquirol in France and by the German clinicians were readily

accepted by Americans. A number of contributions in diagnosis and classification were made in the United States during the latter part of the nineteenth century. These included:

1) *The separation of idiocy from insanity.* This classification may seem self-evident when viewed from the vantage point of the latter part of the 20th century, but this distinction only slowly emerged in the mid-19th century. It was incorporated in the U.S. 1870 census, which counted cases of both "idiocy" and "insanity." This important epidemiological distinction was based on clinical observations that manifestations of idiocy became apparent soon after birth and in early development, whereas insanity occurred in adulthood after apparently normal development during childhood and adolescence.

2) *Awareness of the relationship between life circumstances and mental illness.* The frequency of "nostalgia" as a medical diagnosis was commented upon during the Civil War by many physicians in the Union Army, who observed the symptoms of sadness and grief of young soldiers separated from their homes and families.

3) *Description of the new diagnostic category of "neurasthenia."* Referring to this condition as a disease of American civilization, Beard (1880) described what he believed to be an epidemic of fatigue and weakness, brought about by a rapid urbanization that was "exhausting the nervous system" and causing "weak nerves." A uniquely American categorization, Beard's concept of neurasthenia was popular and provided an apparent neurologic explanation for many bodily and psychological complaints. This theory underlay the work of the neurologist, S. Weir Mitchell (1894), who proposed the therapeutic "rest cure" in which the patient was removed from the family, usually to an isolated rural setting, where rest and rich foods were prescribed and justified by the need to replenish a "weak" nervous system. Implicit in this diagnosis and therapy was a notion that cities and civilization were morally corrupting and causative of mental illness, in contrast to the rural countryside, which was viewed as healthful, refreshing and morally pure. This view became a widespread theme in late 19th-century American writing.

4) *Increased concern about the health hazards of alcohol.* This occurred during the second half of the 19th century consequent to the increase in alcohol consumption. The temperance movement drew public attention to the health consequences of excessive alcohol consumption, leading eventually to enactment of Prohibition laws in 1919.

5) *Identification of drugs leading to addiction.* Morphine derived from opium had come into medical use during the Civil War after the development of the hypodermic syringe and was widely used in

medical practice in the latter half of the 19th century. Musto (1973) has estimated that about five percent of the American population, mostly female, was addicted to opiates during this time. The ongoing effect of morphine addiction upon family life is dramatically depicted in Eugene O'Neill's powerful *Long Day's Journey into Night*, in which the mother's readdiction precipitates a family crisis.

The Beginning of the 20th Century

Most observers of the history of American psychiatry are in agreement that the field reached a low point at the end of the 19th century. The optimism of the moral treatment movement had given way to social Darwinism and custodial practices. In addition, very little research was being conducted, and practitioners attracted to psychiatry seemed to many observers to be of lesser quality than in other fields of medicine.

Some of the most telling aspects of this decline were captured by the neurologist S. Weir Mitchell's lecture to the medical superintendents at their 50th annual meeting in 1894 (Rothman, 1980). An avowed critic of the asylums, he viewed the institutions to be failures as custodial, rehabilitative or teaching settings. Institutions that provided only custodial care could not further the scientific progress of the psychiatry profession: "Where," Mitchell asked, "are your annual reports of scientific study, of the psychology and pathology of your patients? . . . Want of competent original work is to my mind the worst symptom of torpor the asylums now present." He told his audience that so long as "you shall conduct a huge boarding house . . . what has been called a monastery of the mind, you will be unable to move with the growth of medicine, and to study your cases, or add anything of value to our store of knowledge." Even the purist custodial aspect of their jobs was in question: "I have seen hospitals that smelled and looked like second-class lodging houses, and have found their managers serenely contented. You have too long maintained the fiction that there is some mysterious therapeutic influence to be found behind your walls and locked doors. We hold the reverse opinion and think your hospitals are never to be used save as a last resort . . . I think asylum life is deadly to the insane."

Psychiatry as a profession began to change in the decade prior to World War I. It is probably no accident that these professional changes coincided with the emergence of the Progressive movement in American political and cultural life. There seems to be a close historical correlation between periods of improved economic well-being, general intellectual and social ferment, and progressive political movements, on the one hand, and reform in mental health investigators and prac-

tices and new ideas in psychiatric professional activities on the other. This pattern was clearly evident in the decade before World War I, when teaching and research activities developed in the new "psychopathic hospitals" in Boston, Baltimore, Ann Arbor and elsewhere. This was also the period during which psychoanalysis had its first impact upon American psychiatric and intellectual thinking after the 1909 visit of Freud and Jung to Massachusetts and other Northeastern states.

The Influence of Adolf Meyer

The influence of Adolf Meyer on 20th-century American psychiatry has been profound and paradoxical (Klerman, 1979). German speaking, educated in Switzerland, France and England, and trained as a pathologist, Meyer was part of a small group that introduced the new European techniques of neuropathology to America. He also helped introduce Kraepelin's concept of dementia praecox to the U.S. academic psychiatric community. Yet, once in the United States, he was strongly influenced by American pragmatism, social psychology and mental hygiene.

Between the time of his arrival in the United States in 1892 as pathologist at the Kankakee State Hospital in Illinois and 1913, when he was appointed director of the Henry Phipps Clinic at Johns Hopkins, Meyer rose to a position of major leadership in American psychiatry. During these decades, Meyer absorbed the ideas of William James, founder of the first American school of philosophy, the social psychology of G.H. Mead and C.H. Cooley at Chicago, and the new psychotherapy of Morton Prince at Harvard. He wrote his comprehensive and scholarly criticism of Kraepelin's concept of dementia praecox, strove to formulate his own dynamic psychology, and broadened the scope of psychiatry to include what he termed "civic medicine" (Rothman, 1980), emphasizing prevention, outreach, and follow-up clinics and programs that anticipated the community mental health movement in the 1960s.

Although Meyer calls his approach "psychobiology," his psychobiological approach is not the same as the current meaning. Today, psychobiology refers to the influence of biological mechanisms, such as chemical and pharmacological processes, upon mental behavior and connotes activities synonymous with biological psychiatry. Rather, Meyer based his ideas on those of Darwin, and he viewed mental illness as an attempt of the individual to adapt to the changing environment, particularly its psychosocial changes. Focusing on patients' lives, objectively and minutely observed and recorded in patients' "life charts," he emphasized maladaptation and habit as being at the core of mental disorder; disease was the "inevitable and natural development

from a deterioration of habits due in part, at least, to the clashing of instincts and to progressively faulty modes of meeting difficulties" (Meyer, 1950–1952).

Meyer was the first professor of psychiatry at Johns Hopkins University, which was organized following the reforms recommended by the Flexner Report. The Report emphasized research, professional specialization, scholarship and full-time faculty, and became the model for American medical schools. The few other academic centers of psychiatry that emerged after World War I were most often led by students of Meyer, such as Campbell at Harvard and Diethelm at Cornell. It was through the influence of his students that Meyer's contribution is most lasting; particularly the social psychiatric epidemiology efforts of Lemkau, Rennie, Leighton and others, who amplified Meyer's general approach to identify social factors that generate mental illness and mental retardation in specific communities, were important.

In addition to research in social epidemiology, Meyer influenced the mental hygiene movement, the modification of Freudian psychoanalysis and the emergence of the interpersonal school of psychotherapy. His students dominated the leadership of academic psychiatric centers until well after World War II. Many of the American contributions to psychiatry in the 20th century were the consequence of Meyer's approach, and in many important respects he presaged and effected the diverse directions of the multiple schools on the contemporary American scene.

World War II and Its Consequences

World War II had a major impact upon American psychiatry. The experience of the Selective Service System and of the military led to a greater public awareness of the extent of mental illness and mental retardation. World War II led to increasing optimism concerning the treatment of mental illness.

A group of social scientists within the U.S. Army, led by Samuel Stouffer (1950), developed scales and tests to measure anxiety, satisfaction, fatigue and other psychological states among army personnel. With these methods, they studied the relationship of the stress of combat upon susceptibility to breakdown and psychiatric disease.

After World War II, many of the social scientists involved in military research on stress and performance became active in psychiatric research and continued to study stress and its health consequences. Their focus shifted from the stress of combat and the threat of death to the less dramatic stresses experienced in civilian life, such as poverty, low

socioeconomic class, urban anomie and rapid social change (Weissman & Klerman, 1978).

Clinical attention was given to "shell shock" described during World War I and conditions considered "traumatic neuroses." Many forms of psychosomatic disorders were observed, and clinical patterns were found to vary among different armies. During World War I, "soldier's heart" was frequently observed among British troops, and diagnoses of "neurocirculatory asthenia" or anxiety neurosis were common; extensive physiologic and psychological studies of this condition were reported. In contrast, World War II witnessed relatively less cardiovascular disorders, but more reports of gastrointestinal complaints and dissociative states.

Among the most influential American efforts to describe and treat war neuroses were the reports by Grinker and Spiegel in the North African campaign. In their book, *Men under Stress* (1945), they described the use of intravenous amytal to promote therapeutic abreactive reactions. Although these reactions were dramatic, subsequent research by Glass (1955) indicated that this treatment produced only a relatively low rate of return to active duty. Subsequently, the U.S. military modified its psychiatry program, resulting in far less psychiatric disability and morbidity during the Korean and Vietnam Wars.

Brief psychotic states (called "three-day schizophrenia" or "ten-day psychosis") were also reported. These observations seemed to contradict the conventional views of schizophrenia, which emphasized its chronic nature. Although there were many clinical reports of brief transient psychotic states, whose onset seemed to be related to the stress of combat, Glass (1955) demonstrated that while the diagnoses of neuroses fluctuated with combat and occasional transient psychotic episodes undoubtedly occurred, the overall rate of psychoses remained relatively low and stable.

Considerable clinical attention was also given to the forms of personality disorders that rendered individuals unable to cope with military life. Strongly influenced by the psychoanalytic ideas of Karl and William Menninger, precursors of DSM-I were developed in the military psychiatric nomenclatures and in the Veterans Administration classification. They described new conditions, such as "passive-aggressive personality" and "passive-dependent personality."

Post-World War II Developments

The decades following World War II, particularly the 1960s and 1970s, witnessed a proliferation of new theoretical, clinical, and research advances in American psychiatry. These advances included the commu-

nity mental health center movement and the emergence of behavioral techniques and other new forms of psychotherapy. In addition, the past decade has witnessed a neo-Kraepelinian revival whose adherents consist of a small but energetic group of researchers who began applying statistical and psychometric methods to clinical description and diagnosis, strongly influencing the development of DSM-III.

Community Mental Health Movement

After World War II, mental health issues became matters of national concern. The high rates of mental retardation and emotional and mental disorders reported by Selective Service examinations and the large numbers of psychiatric casualties in the military had attracted public attention during the war. During the post-war period the public was alerted to the mental health needs of the large number of veterans and the alarming increase in patients in mental hospitals. In 1950, one half of all hospital beds in the United States were in mental hospitals.

This public concern resulted in the creation in 1955 by Congress of the Joint Commission on Mental Illness and Health. Its 1961 report, *Action for Mental Health*, called for major reform of patterns of care for the severely mentally ill. The impact of this report was apparent in President Kennedy's 1962 message to Congress, which laid the groundwork for 1963–1965 legislation creating the Federal program of community mental health centers.

During the 1960s and 1970s, Federal leadership and funding contributed to major expansion of community mental health facilities and of professional personnel. Utilization rates increased fourfold in two decades as ever larger segments of the general population sought help from mental health professionals. Considerable debate ensued over the extension of psychiatry into community problems and social issues beyond the traditional scope of psychiatry as a medical specialty concerned with patients with diagnosable disorders.

As in the Jacksonian era of the 19th century and in the Progressive era of the early 20th century, the expansion of psychiatric activities in the United States in the period of the expansion of the welfare state during the 1960s was strongly influenced by national social and political forces. These influences were reflected in differences of theory and practice inside the profession as well as controversy in academic and public policy areas concerning the proper role of mental health in the larger social order.

The Federal community mental health program expanded services to large numbers of persons not previously reached, especially children, the elderly and the poor, while also attempting to initiate prevention

and rehabilitation efforts. The rapid growth of these programs generated problems of implementation for the mental health profession and stimulated serious debates concerning evaluation, efficacy and accountability. The movement's achievements were, and continue to be, subject to the vicissitudes of public support and professional commitment. The movement, however, lost most of its programmatic and ideological momentum after the election of Ronald Reagan in 1980.

The Antipsychiatry Movement

During the 1960s and 1970s, an antipsychiatric movement emerged in the United States, with parallel developments in Japan, England, France and Germany. The polemic of Szasz (1961) on the "myth" of mental illness, Laing's (1971) writings rooted in Sartrian existentialism, and Rosenham's study of "pseudopatients" (1973) proved influential in many legal and academic circles.

It is interesting that this movement garnered support in the United States during the decades when psychiatry was pressing far beyond its traditional bounds, especially in community mental health. Although major activity in psychiatry was more directed at this time at programmatic, social and political goals, concern arose over the extension of the mental health profession into social areas where, it was felt, psychiatric expertise could not be justified.

The antipsychiatry writers had a strong influence on the general intellectual thought during the 1960s and 1970s, particularly among sociologists and psychologists, many of whom, known as "labeling theorists," were important teachers in major American universities. Within this framework, mental illness, like other forms of deviance, was viewed as predominantly politically defined and socially reinforced behaviors. Their theories maintained that psychiatric diagnoses of mental illness was a labeling process whereby patients are stigmatized and thereby confirmed in a situation reifying the conditions such labeling was intended to diminish. Further, they held that the stigma separating the mentally ill from the larger population was a form of social control, and that mental health professionals were in danger of becoming instruments of social control rather than advocates of patients' needs (Lemert, 1972; Scheff, 1966, 1975).

The controversies over labeling theory stimulated research on the adverse social and legal consequences of psychiatric practices. Their views strongly influenced many lawyers trained during the civil rights era, who initiated legal suits on behalf of hospitalized mental patients. The legal efforts had divergent results. A significant amount of litigation resulted in increasing the rights of hospitalized mental patients.

Respect for psychiatric expertise in legal, legislative and public opinion arenas was often diminished by critics calling into question the reliability and validity of diagnoses of mental disorders.

New Directions in Psychopathology

In the late 1950s there was a growing awareness among clinicians and researchers that the absence of objective, empirically based methods for describing psychopathology was limiting research efforts. Much of this concern appeared after the introduction of new psychopharmacologic agents and the need to assess their efficacy by controlled clinical trials. Many rating scales were developed in response to this need, including those by Lorr (1962), Hamilton (1960) and Overall (1962). Self-report instruments, such as the *Hopkins Symptom Checklist* (HSCL) (Derogatis et al., 1973) and the *Profile of Mood States* (POMS) (McNair, 1971) were also formulated. In addition, specific scales for depression and for anxiety were developed by Hamilton (1960), Beck (1969) and Zung (1965), among others.

These new advances in clinical psychopathology drew upon existing psychometric methodologies, particularly those developed for educational testing, and the new statistical techniques, including factor analysis and other multivariate methods. The availability of high-speed electronic computers in the early 1960s made possible the application of many statistical procedures previously too laborious to be undertaken manually.

In the 1950s and 1960s, these methods were applied to the description of symptoms of patients entering clinical drug trials and to assessment of the multidimensional nature of change produced by therapeutic intervention, particularly new drugs and community programs.

During the 1970s, psychometric methods were applied to problems of reliability and validity of categorical diagnostic categories. In this effort there has been a convergence of the neo-Kraepelinian approach (Robins & Guze, 1970, 1972), which emphasizes the importance of multiple classes of psychiatric illness, with the research methods and techniques of psychometrics and biostatistics. The first products of this collaboration were the *Research Diagnostic Criteria* (RDC) and the *Schizophrenia and Depression Schedule* (SADS) developed by Spitzer, Endicott and Robins (1975) as part of the NIMH Collaborative Psychobiology of Depression Project (Katz & Klerman, 1979). The RDC provided a compendium of operational criteria for 22 diagnostic classes. Based on the general approach of Robins and Guze (1970, 1972) and the Washington University/St. Louis group of neo-Kraepelinians, it was paired with a

structured interview, the SADS. Together, the SADS-RDC provided major tools for systematic assessment of psychopathology and for assignment of patients to diagnostic classes. They were rapidly accepted as the standard clinical research procedures in the late 1970s in the United States.

Spitzer was appointed Chair of the APA Task Force to develop the DSM-III, and he and his associates developed operational criteria for many diagnostic classes (over 100 categories in all). They also devised a multiaxial system to aid diagnostic and treatment decisions. To test the reliability and clinical utility of the new DSM-III, a field trial involving over 400 psychiatrists was undertaken. Efforts to establish validity of diagnostic categories were also begun, based on principles articulated by Guze (1970) and Robins (1977), which emphasized external validation by correlation with laboratory studies, follow-up of clinical course and outcome, family and genetic associations, response to treatment, and social and economic factors.

The Neo-Kraepelinians

During the 1970s, a small group of neo-Kraepelinians emerged in American psychiatry and had major impact on research activity in psychiatric academic circles (Klerman, 1977) The neo-Kraepelinian point of view includes a number of normative propositions:

1) Psychiatry is a branch of medicine.
2) Psychiatric practice should be based on the results of scientific knowledge derived from rigorous empirical study (as contrasted with discursive and impressionistic interpretation).
3) A boundary exists between the normal and the sick and this boundary can be delineated reliably.
4) Within the domain of sickness, discrete mental illnesses exist and are not myths. Rather than a unitary phenomenon, mental illness consists of many disorders, and it is the task of scientific psychiatry, as well as other medical specialties, to investigate their etiology, diagnosis and treatment.
5) Psychiatry should treat individuals requiring medical care for mental illnesses, as opposed to those in need of assistance for problems-in-living and unhappiness.
6) Research and teaching should emphasize diagnosis and classification explicitly and intentionally.
7) Diagnostic criteria should be classified and research should validate the criteria for this classification.

8) Departments of psychiatry in medical schools should teach these criteria and not deprecate them, as has been the case for many years.

9) Research efforts directed at improving the reliability and validity of diagnosis and classification should use advanced quantitative research techniques.

10) Research in psychiatry should use modern scientific methodologies, especially from biology.

As is clear from these highly prescriptive propositions, the Neo-Kraepelinians were not interested in describing current psychiatric practice; they wanted to change it. Although the Neo-Kraepelinians tend to research genetic hypotheses for mental illness, a categorical approach is not, in my opinion, necessarily unique to biological psychiatry. For example, Freud and many of his early followers, such as Abraham (1927) and Glover, proposed a classification of mental illness based on psycho-sexual stages of development. In current research practice, however, most Neo-Kraepelinians emphasize the biological bases of mental disorders, and, as a group, they are neutral, ambivalent or at times even hostile to psychodynamic, interpersonal and social psychiatric approaches.

Theoretically, the concept of separate syndromes is compatible with behavioral and social psychiatric approaches. The writings, research efforts and clinical practice of the small but influential group of Neo-Kraepelinians in the States nevertheless remains closely identified with the biological school—part of a general trend in American psychiatry toward greater integration with general medicine. Although the impetus for this trend has come from several sources—professional, scientific, ideological and economic—one consequence has been a greater concern for the medical identity of U.S. psychiatry.

The initial statement of the Neo-Kraepelinian point of view appeared in the introduction to the textbook, *Clinical Psychiatry*, by Mayer-Gross, Slater and Roth, published in Britain in 1954. Strongly critical of psychoanalysis, psychotherapy, and social psychiatry, this book was a resounding and aggressive reaffirmation of the traditional Kraepelinian approach. In the United States, Neo-Kraepelinian activity originated at Washington University/St. Louis. Its early spokespersons were E. Robins, George Winokur and Sam Guze. Winokur has been active in familial-genetic studies of affective disorder, and Guze is best known for his research with Briquet's Syndrome and the reformulation of the category of "hysteria."

One impetus for these diagnostic efforts derives from psychopharmacology research and practice. The patterns of response to the major classes of therapeutic drugs has been striking in the degree to which

Kraepelin's diagnostic distinctions have been followed. Among the "functional" psychoses, schizophrenia, paranoia and other disorders of thinking respond to neuroleptics, while among the affective disorders, manic states respond to lithium and the depressions to tricyclics. The general pattern of response seems to follow the general outline of the major disorders. As the numbers of psychopharmacologic agents available grew in the 1960s and 1970s, efforts were undertaken to provide reliable and valid predictors of which types of patients were likely to respond to the various classes of drugs.

These new diagnostic procedures have also been effective in responding to the challenges from the antipsychiatrists and the labeling theorists. One of the main arguments put forth by the critics of psychiatry was the apparent low reliability of psychiatric diagnoses and the lack of validity for the categories. In response to this criticism, successful efforts were undertaken to better understand the sources of unreliability, and they have been located and analyzed: Efforts have been made and are continuing to be made to overcome reliability obstacles. For example, Fleiss, Spitzer and associates (1972) applied the statistic "kappa" to measure more accurately the degree of concordance among diagnosticians. In addition, training techniques have been developed using videotapes and case vignettes to aid in applying DSM-III operational criteria more precisely.

IV. The Contemporary Schools of American Psychiatry

The previous sections of this paper have described the major scientific and social forces within the profession and from the larger society, leading to the emergence of multiple schools of American psychiatry. Each of the major schools are now discussed with regard to their general background and scientific orientation, and their specific positions vis-à-vis diagnosis and classification of disorders.

The Decline and Rebirth of Biological Psychiatry

Biological psychiatry can trace its origins to mid-19th-century developments in European countries, notably France and Germany. The term "psychiatry" first appeared in the mid-19th century during the time of rapid emergence of other medical specialties. In the German-speaking countries, new advances in biology were applied to mental disorders. Bacteriology, pathology, physiology and biochemistry became separate

scientific fields whose methods were quickly applied to psychiatric illnesses, often with striking success.

The tenets of the biological school were codified in the successive editions of Kraepelin's influential textbook (1919), which incorporated general principles for classifying mental disorders on the basis of etiology. Kraepelin also delineated dementia praecox and manic-depressive psychoses.

After the discoveries in 1911 that the Treponema organism was responsible for CNS syphilis, and in 1921 that pellagra was due to a deficiency in vitamin B6, the field of biological psychiatry went fallow: New discoveries were uncommon and scientific work became undistinguished. At the same time, the available somatic treatments seemed inhumane, with many biological psychiatrists showing an overenthusiasm for interventions such as colostomy, adrenalectomy and excision of teeth, justified by notions of autoinfection and other unsubstantiated theories. Psychosurgery was performed widely without adequate evidence as to its efficacy or safety. By the end of World War II, biological psychiatry had become identified with therapeutic insensitivity and scientific mediocrity.

A resurgence of biological psychiatry occurred in the mid-1950s with the development of new psychopharmacologic agents, particularly the phenothiazines, the effects of which were to create a therapeutic revolution and to change the nature of psychiatric institutionalization. With the development of lithium, the tricyclics and MAO inhibitors for affective disorders, wide, controlled testing of these agents in clinical practice was begun.

Efforts of laboratory investigators to understand the mode of actions of the new drugs witnessed a renewed interest in relating psychiatry to neurobiology. The U.S. leader of these investigations was Seymour Kety and his associates at the NIMH Intramural Program at Bethesda, Maryland.

Techniques from enzymology, neuropharmacology, neurophysiology and neurochemistry were rapidly employed to understand the CNS action of the new psychotropic agents and to elucidate possible biological abnormalities in schizophrenic, manic-depressive and other patient groups.

Developments in psychiatric genetics, following upon the discoveries of molecular biology, opened up an additional area of investigation of the etiology of psychiatric illness. Kety and his associates were the leaders in these explorations as well. Their elegant Danish cross-fostering studies (1968) permitted the first demonstration of the interaction of genetic and environmental factors in the etiology of schizophrenia.

As has been noted, clinical responses to the new drugs revealed patterns that followed classic categorization of major disorders. The

therapeutic efficacy of these psychopharmacologic agents stimulated a search for clinical predictors of response for diagnostic subclasses. For example, the clinical picture of endogenous depression has been found to predict response to tricyclics, and attempts are now underway to develop diagnostic criteria for "atypical depressions" that respond to MAO inhibitors.

Although clinical psychopathological features have had considerable utility in predicting response to drugs, the almost total reliance on behavioral and symptomatic observations for clinical decisions has prompted dissatisfaction. In the context of this dissatisfaction, current efforts to develop biological laboratory tests are increasing.

At the present time, the biological school in psychiatry is closest to the mainstream of general medicine. Its proponents are a minority within the practitioners in the United States, based on surveys of the self-defined identity of psychiatrists, with a higher proportion in academic and research settings (Armor & Klerman, 1968). Although its adherents are relatively few in number among clinicians, the quality of research in biological psychiatry and the promise of future knowledge have been dramatic. Increasing evidence for the efficacy of psychopharmacologic agents, based on results of controlled clinical trials, has produced a greater willingness of practitioners to use drugs in the treatment of patients who previously would have had recourse only to much less rigorously tested somatic treatments or to some form of psychotherapy. These accomplishments have captured the imagination not only of psychiatrists, but also of other physicians, mental health professionals, the public-at-large and government policy makers.

The Emergence of the Psychoanalytic School

Hale (1971) and other historians have documented the rapid infusion of psychoanalysis into American psychiatry and intellectual thought after Freud lectured at Clark University in Worcester, Massachusetts, in 1908. The psychiatric scene in the United States at the turn of the century was characterized by crises in the three prominent modes of treatment of mental illness: the custodial nature of the institutional area was woefully inadequate and support for the "asylum" was in decline; the somatic mode was employed by neurologists increasingly frustrated in their attempts to deal with problems involving the emotions; and the new psychotherapies used eclectic investigation of suggestion and reeducation techniques.

This state of dissatisfaction provided fertile ground for the acceptance of Freud's concepts and methods involving the unconscious. The

leading psychologists and psychotherapists of the time, most particularly William James and Morton Prince, accepted Freud's theories of infantile sexuality and repression as they sought to understand more fully the nature of psychological conflict. The intellectual network that included James, Prince, Boris Sidis, the neurologist James Jackson Putnam, Adolf Meyer and others helped provide acceptance of the psychoanalytic movement in the medical academic centers of Boston, Baltimore and New York.

Freud's ideas attracted physicians outside as well as inside the psychoanalytic movement, such as William Alanson White, director of St. Elizabeth's Hospital in Washington, DC, who had learned from Meyer to study patients' "mental makeup" and life experience. Psychiatric hospitals and medical schools began to employ and teach psychoanalytic techniques, influential medical textbooks sympathetic to psychoanalysis appeared, and between the time of Freud's visit in 1909 and the end of World War I in 1918, the number of interested physicians had markedly increased across the country.

The pervasive influence of Adolf Meyer, the most influential psychiatrist on the American scene between the two World Wars, was also important. Because psychoanalysis emphasized psychological and environmental factors rather than heredity and somatic disturbances, Meyer initially found Freud's approach stimulating in his own explorations and critiques of dementia praecox, as well as in his psychobiological efforts to break through a rigid body/mind dualism. Although he never fully embraced psychoanalytic concepts or methods, in 1930 he stated that Freud had organized and articulated psychological tenets more telling than any in the previous 30 years, in terms close to the "heart of passion and conflict" (Hale, 1971).

The social climate in the United States also nurtured the belief in cure of mental illness through treatment focused on psychological conflict, repression, childhood experience and dreams. The psychoanalytic approach came to be regarded as having clinical value and theoretical significance. Garnering support from diverse professional, academic and lay sources, psychoanalysis established an influential position in American psychiatry and culture.

During the early history of the psychoanalytic movement, its theorists and clinicians accepted the basic Kraepelinian views of nosology. Moreover, in many ways, Freud was the "Kraepelin of the psychoneuroses," having written many of the original descriptions of anxiety neuroses, obsessive-compulsive states, conversion hysteria and phobia. Freud himself wrote a number of important papers on the distinction between neuroses and psychoses, basing the distinction on a number of criteria: (1) regression from secondary to primary thinking, (2) different levels in fixation of psychosexual development, (3) the

influence of narcissism, and (4) loss of reality testing in psychoses and retention of reality in neuroses.

Many early psychoanalytic workers adopted a nosologic model that related the individual psychoses, neuroses and other mental disorders to fixations at specific states of psychosexual development. Abraham (1927) and Fenichel (1945) were explicit about this model and their writings included charts in which connections are drawn between particular states of child development and the predisposition to specific adult disorders.

This model, however, became increasingly untenable in the 1940s, when alternative models were attempted in order to incorporate and apply the new concepts of child development, particularly those proposed by Anna Freud.

Social Psychiatry

Adolf Meyer's psychobiology extended the Darwinian principle of biological adaptation to include the human organism's psychic adaptation to its social environment. In Meyer's view, psychiatric illness represented an attempt, or usually the failure of an attempt, by the individual to cope with environmental demands. In his writings, however, Meyer was vague as to the specific psychopathogenic characteristics of the social environment or how they were related to the emergence of specific mental illnesses. However, his students, especially Lemkau, Pasamanick, Rennie and Leighton launched the school of social psychiatry with their field studies of social epidemiology in the United States after World War II.

Four aspects of the social environment became the focus of social psychiatric interest: social class, stress, civilization and urbanization, and the social structure of mental institutions:

(1) *Social class.* The observation that certain mental illnesses were more prevalent in lower social classes was reported at a time of national concern with poverty and other consequences of inequality in the United States. This influential line of research began with the work of the Chicago school of sociology, particularly by Faris and Dunham (1939), who used ecological methods to demonstrate differences in hospitalization associated with social class. Subsequently, Hollingshead and Redlich (1958) studied the prevalence of treated mental illness in New Haven, Connecticut. Although their work has been criticized for its failure to distinguish adequately between incidence and prevalence and for its restriction of the sample to treated cases, they nevertheless demonstrated a strong relationship between lower

social class and schizophrenia. Moreover, they documented the powerful influence of social class on availability of treatment resources and health-seeking behavior.

(2) *Stress.* During World War II, an extensive social science research program was conducted by the U.S. Army that included efforts relating neurotic symptoms to combat stress (Stouffer, 1950). Although military personnel had passed extensive Selective Service medical and psychiatric screenings prior to induction, some among them nonetheless developed psychiatric symptoms during combat. Researchers thus concluded that combat neuroses were precipitated by stress rather than caused by predisposing vulnerability.

The thesis that mental illness in the military was due to precipitating stress factors led to many studies on the relationship between psychosocial life events and mental disorders in civilian life. Holmes and Rahe (1967), for example, initiated a series of studies on the role of various stressors in increasing the relative risk of becoming ill; natural disasters (such as hurricanes and floods), life events (such as grief or loss of a job), and economic changes (such as the closing of an industrial plant) were selected as known to increase risk of medical and mental illness.

(3) *Civilization and urbanization.* The earliest speculations as to the causes of mental illness arose during the Enlightenment when mental illness was viewed as the result of civilization. Rousseau's concept of the "happy savage" was reflected in the epidemiologic hypothesis that mental illness does not occur in the natural (i.e., uncivilized) state of man, an hypothesis that Srole and Fischer (1980) refer to as the "paradise lost" doctrine of mental illness. This romantic view of primitive societies rested on the assumption that these societies do not have psychoses, an assumption contradicted by cross-cultural research demonstrating that mental illnesses, including psychosis, occur widely throughout both literate and nonliterate societies (Murphy, 1976).

Goldhammer and Marshall (1953) also tested this hypothesis using data on rates of mental hospitalizations in Massachusetts. Their research indicated that when the rates are corrected for the changing age distribution of the population, no trend toward increased hospitalization because of psychoses during any particular time period could be documented for patients below the age of 50 since the 19th century.

Closely related to civilization as a focal point for social psychiatric investigation is urbanization associated with view that urban social life has adverse mental health effects. This epidemiological thesis predicts that mental illness will be more prevalent in urban than rural communities.

Srole and Fischer (1980) recently tested this hypothesis in a follow-up study of persons interviewed in the Midtown Manhattan study of 1954. When controlled for age and decades of Manhattan living, more recent birth cohorts showed *better* mental health compared to the earlier generation. This finding was due mainly to an improvement in the mental health of the "new breed of women" emerging in recent years.

Parallel to the 1954 Midtown Manhattan study has been the important study of Leighton and associates in Nova Scotia (1963). Their work tested the thesis that rapid social change, particularly from a rural economy to an industrial social economic structure, results in breakdown of social cohesion and increases social disorganization, reflected in increasing rates of mental illness. Their concept of social disintegration bears many similarities to Durkheim's *anomie* (1951).

(4) *The social structure of mental institutions.* After World War II, a number of successful collaborations were undertaken between psychiatrists and sociologists to investigate the social, psychological and institutional characteristics of mental hospitals. These studies demonstrated the adverse impact of the mental hospital social structure on clinical outcome. Excessive bureaucracy, hierarchical authority structure, the power exerted by nonprofessionals and the pervasive role of ideology were emphasized. These findings revived interest in the moral therapy of the early 19th century, with its emphasis on the individual and the role of the institutional environment in actively promoting recovery.

The results of these investigations questioned whether much, or even all, of the clinical features associated with schizophrenia and other chronic psychoses were due to the intrinsic nature of the illness or to the depersonalizing and dependency-producing features of the social environment of the institution.

In England, the concept of "institutional neuroses" was proposed to account for these effects. In the United States, Gruenberg (1966) identified a "social breakdown syndrome" from the effect of the social environment on the course of illness, particularly those outcomes with deterioration. In part based on these studies, many attempts were made to reform mental hospitals. American psychiatrists adopted many of the techniques originating in the United Kingdom, including "open door" policies, day treatment programs, and efforts at social and vocational rehabilitation. Innovation along these lines has been less than prominent in the past decade, during which attention has shifted from the hospital to the community as the main locus of treatment.

The closing of mental hospitals, similar to the widespread closing of tuberculosis hospitals during the 1950s, has remained an unrealized hope. Rather, community placement and deinstitutionalization have often witnessed continuing chronicity and social disability among pa-

tients, indicating that a considerable proportion of chronic social disability is attributable to the illness rather than to the adverse effects of the institutional social structure.

The social psychiatry school made two main contributions to research: (1) Its efforts enlarged the scope of psychiatric research concerns by focusing on institutions and large populations; and (2) it brought social science theory and methodology into the field of psychiatric research. Although psychiatric epidemiologic efforts have broadened the class of relevant independent variables (the causal risk factors) associated with mental illness, students of social epidemiology have paid relatively less attention to the dependent variables (the specific mental disorders).

There was, in fact, a tendency in many epidemiologic studies after World War II to depreciate specific diagnoses and to rely upon unidimensional disability and mental impairment scales (Weissman and Klerman, 1978). This tendency was reversed with the application of the *Research Diagnostic Criteria* (RDC) and other new techniques in community surveys. NIMH developed the Epidemiologic Catchment Area (ECA) program which involved community surveys of large samples of patients at multiple sites using a structured interview, and the *Diagnostic Interview Schedule* (DIS) formulated by Robins (1981), which allows for diagnostic assessment consistent with DSM-III categories. These efforts have provided a rapprochement between the new emphasis on diagnostic categories and the theoretical and methodological advances in sampling and measurement of social risk factors developed by social psychiatric researchers.

The Behavioral School

A behavioral school of psychiatry emerged in North America in the 1960s. Although its intellectual and scientific origins are to be found in the work of Pavlov and Schenechov in Russia and the early writings of Watson on behaviorism in the United States, the main theoretical support for contemporary behaviorism is derived from the work of B.F. Skinner.

The growth of behaviorism as a psychiatric school was associated with considerable controversy and tension between M.D. psychiatrists and Ph.D. clinical psychologists. Most behavior therapists and researchers hold Ph.D.s, although a sizable and influential minority are behaviorally oriented psychiatrists.

Whereas the main focus of behavior therapy, research and practice has been on the treatment of symptomatic states, such as phobias, obsessive-compulsive states or sexual dysfunction, a number of theo-

retical and ideological aspects of behavior therapy bear upon issues in nosology, diagnosis and classification. On the whole, behaviorists are skeptical of diagnostic categories and phenomena that cannot be directly observed, such as intrapsychic conflicts or unconscious mental processes. They have, thus, been highly critical of psychodynamic concepts and similarly skeptical about the standard view of personality states or personality disorders as enduring.

The behaviorists' emphasis on directly observable behavior, rather than inner mental states, has contributed to their extensive use of rating scales, self-report methods and patients' diaries. Psychometric techniques that have been developed, usually rating scales, have been used to quantify the magnitude of symptoms, such as phobias and obsessive-compulsive behavior. Much less attention, however, has been given to problems of differential diagnosis or to a syndromal approach.

London (1971) called attention to the strong ideological components in the behavioral approach. He argued that the claims by behaviorists that learning theory provides a scientific basis for clinical practice, as well as their attack on mental entities, appear to him to be related more to the need of behavior therapists to separate themselves from their psychoanalytic and psychiatric colleagues than to a large body of directly relevant scientific evidence.

V. Research Approaches to the Diagnosis and Classification of Selected Disorders

Having described the historical background leading to the development of multiple schools within U.S. psychiatry, I now describe briefly how these schools apply their principles and methods to issues in the diagnosis and classification of selected disorders. In the context of general trends in American psychiatry, I focus on recent efforts, based on the Third Edition of the *Diagnostic and Statistical Manual* (DSM-III).

Schizophrenia and Related Conditions

During and following World War II, American psychiatry adopted an expanded definition of schizophrenia. In part this was due to the strong influence in teaching institutions of Bleuler's concept of schizophrenia, which was broader than Kraepelin's dementia praecox.

As the concept of schizophrenia broadened, it came to encompass all nonorganic psychoses. American patients diagnosed as schizophrenic overlapped with patients diagnosed by European psychiatry as having

manic, schizoaffective and depressive psychoses. Moreover, the expanded diagnostic category of schizophrenia came to include many nonpsychotic states, characterized by chronic difficulties in social adjustment, impairment of personality functions and regressive phenomena, even though these states might not involve impairment of reality testing or loss of higher mental functions.

In the 1960s, a number of efforts led to a reevaluation of the broad concept of schizophrenia and the movement toward a narrower definition. These include:

1) *The U.S.-U.K. Diagnostic Project*. In the late 1950s, M. Kramer, head of the NIMH Biometrics Program, took note of the marked discrepancy between the United States and the United Kingdom regarding the numbers (in rates per 100,000) of patients hospitalized and diagnosed as schizophrenic or depressive in each country. He questioned the extent to which these statistics reflected true differences in the incidence and prevalence of the disorders or were due to diagnostic differences. Kramer (1969) and Zubin (1969) at the New York State Psychiatric Institute enlisted colleagues at Maudsley Hospital, notably Wing and Cooper (1974), to launch the U.S.-U.K. joint project. Collaborative research teams were organized in London and in New York, and standardized interview instruments were developed, indexing Wing's *Present State Examination* (PSE). This study documented that the U.S.-U.K. differences in hospitalization rates were mainly due to the different criteria employed in making diagnoses: The British psychiatrists were found to be more likely to diagnose affective disorders for cases that U.S. psychiatrists diagnosed as schizophrenic.

2) *The advent of lithium*. Support for a narrower diagnostic concept of schizophrenia was provided by the efficacy of lithium for bipolar patients. This clinical advance permitted a reduction in the number of patients diagnosed as schizophrenic by removing those with manic symptoms, particularly excitement and overactivity, from the large psychiatric group. In addition, the reports that some patients clinically diagnosed as schizophrenic or paranoid also responded to lithium prompted further reassessment of diagnostic practices.

3) *The development of standardized criteria*. The diagnostic criteria first described by Feighner and the St. Louis group (1972) were found applicable to several research efforts requiring more specific means for distinguishing patient classes. These criteria were later incorporated and expanded into the *Research Diagnostic Criteria* (RDC) developed by Spitzer, Endicott and Robins (1975) for the NIMH Psychobiology Program (Katz & Klerman, 1979) and then into the DSM-III and the DSM-III-R.

4) *The WHO International Pilot Study for Schizophrenia.* The IPSS demonstrated the feasibility of employing standardized criteria in many countries, as well as documenting the similarities and differences between U.S. diagnostic practices and those of other countries (WHO, 1978).

With DSM-III, the U.S. nomenclature shifted to a narrower definition of schizophrenia. In fact, there is now concern that the DSM-III, especially the requirements of a 6-month duration, may be too narrow. As has been noted, the psychoanalytic and interpersonal schools came to deemphasize the descriptive Kraepelinian formulations of psychopathology. Rather than focusing on psychotic manifestations of delusions and hallucinations as necessary criteria for diagnosis of schizophrenia, the patient's inner conflicts and defences, family patterns, interpersonal relations, and social functioning were emphasized.

Researchers and practitioners of the interpersonal school continue to emphasize psychosocial and psychotherapeutic factors with the schizophrenic patient and/or the family, although these efforts are less prominent than in the 1950s and 1960s. Through the formulation of multidimensional assessments that include social adjustment, family relations, personality and occupational factors, and community integration, their work has broadened the range of outcomes to include more than changes in symptoms.

After the studies on New Haven reported by Hollingshead and Redlich (1958), social psychiatric researchers focused their efforts in the 1960s on the role of social class in relation to schizophrenia. This line of research seems to have reached an impasse, with relatively little resolution of the controversy as to whether the social class differences among individuals with the illness reflect true differences in incidence and prevalence, or differences in access to and utilization of treatment facilities. Another related, persistent issue also remains unsolved: Does the accumulation of treated cases in the lower socioeconomic classes reflect social drift within and/or across generations due to adverse consequences of illness? Or does it represent the consequences of pathogenic features of lower socioeconomic class experience?

The behavioral school has paid relatively little attention to diagnostic issues in schizophrenia. Behaviorists have experimented with reinforcement schedules and token economics used in the inpatient treatment setting and with social skills training useful for rehabilitation, particularly in patients' transition to community living after discharge. Lieberman at UCLA and Camillio State Hospital and Paul in Illinois are prominent in these efforts.

The American fascination with the broad definition of schizophrenia was associated with little interest in other "functional psychoses." Occasional reports have appeared on paranoid psychoses, and the debate

continues as to whether paranoid states are to be subsumed under schizophrenia or should be regarded as a distinct diagnostic group. The schizoaffective diagnosis has not gained wide acceptance in U.S. clinical practice and the studies devoted to its description or validation remain relatively few. The "third psychosis," schizoaffective states and cycloid psychoses, have slowly gained attention among researchers (Winokur, McCabe, Tsuang and Clayton, Guze).

The Affective Disorders

DSM-II and the ICD-8 did not group the affective disorders as one diagnostic class, but separated them into the psychotic and neurotic categories. The recent trend in the United States has been to group the affective disorders together as a diagnostic class, a tendency that has minimized, but not eliminated, the distinction between psychotic and neurotic forms. This trend is clear in research employing the RDC, as well as in the formulation of the large category comprising all affective disorders in the DSM-III and DSM-III-R. The creation of this category with several subclasses was based on the large body of research during the 1960s and 1970s on psychopathologic, biological and therapeutic aspects of depression and mania.

The concept of bipolar affective disorder has been widely accepted for its clinical utility in predicting positive response to lithium and adverse response to tricyclics, and has proven a strong spur to research on genetic and biochemical aspects of the disorders.

The concept of unipolar depression is less well accepted. All that is not bipolar is not unipolar. DSM-III does not specify a unipolar category.

The concept of neurotic depression has been radically revised. Defined in terms of multiplicity of factors, including long-term personality difficulties, precipitation by acute stress, underlying unconscious conflicts, as well as others, the DSM-II diagnosis of psychoneurotic depressive reaction was among the most common diagnoses in clinical practice. Research and clinical experience have increasingly questioned the utility and validity of this concept (Klerman et al., 1979; Akiskal, 1978), contributing to the deletion of the diagnostic category in the DSM-III.

Considerable research on the role of life events as possible precipitants of various forms of affective disorder has led to a questioning of the validity of a separate category of "reactive" or "situational" depression (Hirschfeld, 1980). Although life events may increase the risk for a wide variety of disorders, including schizophrenic and medical con-

ditions as well as affective disorders, life events as unique precipitants of any clinical form of affective disorder is increasingly in question.

Attention to endogenous depression has increased. R. Kuhn observed that patients with endogenous depressions responded to tricyclics (Kuhn, 1958). Factor-analytic studies were initially undertaken by Kiloh and Garside (1963) and others in the Newcastle group. Numerous replications of the factor-analytic studies in the United States (Mendels & Cochrane, 1968) identified a cluster of symptoms including early morning wakening, loss of interest in activities and pleasure, loss of appetite, loss of weight and psychomotor change, whether in the direction of agitation or retardation. Evidence has accrued that this symptom cluster is both independent of precipitating life events and highly predictive of response to ECT and to tricyclic antidepressants.

A major advance in classification of affective disorders was the proposal by Robins and Guze (1972) to separate primary and secondary depressions when using the criterion of temporal coexistence of other psychiatric conditions, particularly schizophrenia and alcoholism. Klerman and Barrett (1973) proposed that the diagnosis of secondary depression be extended to include conditions associated with preexisting medical disorder or drug reactions. The occurrence of mania secondary to medical conditions has led to a proposal for the diagnostic category of secondary mania (Krauthammer & Klerman, 1978).

The large number of ambulatory patients with symptoms of both anxiety and depression generates nosological confusion and diagnostic uncertainty. In clinical practice, the coexistence of both symptoms tends to be diagnosed as anxiety disorder, most often treated with antianxiety drugs of the chlordiazepoxide series. However, a number of studies have questioned the therapeutic efficacy of this class of drugs in depressions. It is possible that a separate category for anxiety-depression will appear in future nomenclatures.

Although use of the classic psychotic-neurotic distinction has diminished, the presence of delusions and other manifestations of psychoses is of clinical and therapeutic importance. Patients with delusions and hallucinations respond poorly to tricyclic antidepressants. The nosologic significance of this finding for the classification of affective disorders is still uncertain. The importance for treatment decisions in these cases, however, has gained increasing attention. Uncertainty still exists as to whether patients with delusions as a feature of their depressions are best treated with a combination of tricyclics or with ECT.

Disorders Previously Considered "Neurotic" Conditions

The decision to eliminate "neurotic conditions" as a separate category in DSM-III has generated considerable controversy. Many members of the clinical and academic community, particularly those influenced by psychodynamic thinking, have reacted negatively to this decision. The rationale governing this change was based on dissatisfaction with the vagueness of criteria for separating psychotic from neurotic conditions. Also, more significantly, there was concern that the terms "neurotic" and "psychotic" had become confounded with etiological presumptions—psychotic conditions were presumed of constitutional, genetic or biochemical origin, while neurotic conditions resulted from environmental, personality or psychosocial factors.

Within the group of conditions categorized diagnostically as "neurotic" in DSM-II, and still grouped as such in the ICD-9, the individual disorders remain relatively unchanged, although their grouping has been changed. Obsessive-compulsive and generalized anxiety disorders are subsumed in DSM-III under the larger category of anxiety disorders. Within this category, panic disorder and agoraphobia have been separated from other phobias. The justification for this change rests not only on differences in subjective experience and clinical course, but also on differences in treatment response. In clinical trials, agoraphobia and panic attacks have been shown to be relatively unresponsive to antianxiety drugs of the benzodiazepoxide type other than alprazolam, but responsive to tricyclic antidepressants and MAO inhibitors.

Behavior treatment has proved increasingly effective with agoraphobic patients in the United States and in the United Kingdom. However, many English thinkers do not accept Klein's distinction between panic disorder and generalized anxiety, and the division of agoraphobia from other forms of phobias. Further research will be required to reconcile these differences (Roth & Argyle, 1988).

Another controversial new diagnostic category is somatization disorder. This term derives from research by Guze and his associates (1972) on Briquet's Syndrome, and was proposed in an attempt to reduce the confusion and emotionally charged responses to diagnosis of "hysteria."

DSM-III retains the category of disassociative disorders and allows for separate diagnosis of the various forms (amnesia, fugue, multiple personality and depersonalization). Although these conditions are seen infrequently, the psychopathology is often dramatic, and increased understanding is important for theory and research efforts.

The behavioral school has been most attentive to the phobias, obsessive-compulsive states and forms of psychosocial dysfunction, with

which behavioral psychotherapy has been most successful. Although the development of behavioral interventions depends in large part on delineation of psychopathologic states based on symptoms, there is a strong antinosologic bias within the behavioral school, and research patients have been selected on the basis of predominant behavior and manifest symptoms, such as phobias or sexual dysfunction. However, as the range of application of behavioral psychotherapy has expanded, some rapprochement with nosological diagnosis has begun to occur, and investigators using behavioral techniques are increasingly using structured interviews and diagnostic algorithms in selecting research patients (Barlow et al., 1986).

Personality Disorders

Recent American trends with regard to the diagnostic classification of personality disorders have been reviewed comprehensively by Frances (1980) and also by Vaillant and Perry (1980). Both papers discuss a number of important trends on the American scene with regard to nosology and research of these disorders.

Dimensions of the disordered personality and the healthy individual are both similar and vastly different. While in some instances the clinical disorders (obsessive-compulsive states) appear to be quantitative extensions of healthy mechanisms, in other instances they appear to be discontinuous from normal behavior, as in the case of the antisocial personality. In the case of psychodynamic ego, their manifestations are modified adaptively in healthy individuals and are greatly different from manifestations seen as clinical conditions meriting treatment. Yet they are the same defenses.

Most researchers on personality in psychology use dimensional assessment methods relying heavily on data from self-report and interviews to produce quantitative measures of traits, attributes, and characteristics. With the advent of computers, multivariate statistical techniques, particularly discriminate function and factor analysis, have been applied to many of the older personality inventories, in particular those developed by Cattell (1957), Murray (1953) and the MMPI. The attempt in these efforts has been to develop psychometrically pure measures, not only of individual personality traits, but also of the clustering together of various traits into patterns, types or constellations. As yet, the relation of these approaches to the clinical disorders remains relatively unclear theoretically, empirically and clinically.

DSM-III included a number of new personality disorders derived mainly from the clinical experience of the psychoanalytic and interpersonal schools. The two conditions in DSM-III reflecting this influence

most are "narcissistic personality disorder" and "borderline personality disorder." Narcissistic personality disorder is based on concepts of American psychoanalytic writing and practice articulated by Kohut and his associates (1966, 1971). The reliability, validity and correlates of narcissistic personality disorder are being systematically studied.

The borderline personality disorder was originally described by Knight (1953), who delineated borderline schizophrenic states in a similar manner to prior descriptions of "latent" or "ambulatory" schizophrenia. Knight's ideas also contributed to the extensions of the definition of schizophrenia. In the mid-1960s, a gradual shift in focus occurred with the publication of a number of papers focused on enduring personality features rather than the transient psychotic states. The earlier concept of borderline schizophrenia with transient psychiatric states has been incorporated in DSM-III as "schizotypic personality disorder," a disorder presumably different from the borderline personality disorder. Efforts have been made to apply quantitative psychometric approaches for the diagnosis and treatment of the borderline personality disorder, particularly in the work of Gunderson and Singer (1975), Grinker (1977), and Perry and Klerman (1978).

A number of the classic personality disorders remained relatively unchanged in DSM-III: paranoid personality disorder, schizoid personality disorder, histrionic personality disorder (previously called hysterical personality), antisocial personality disorder (previously called sociopathy), compulsive personality disorder and dependent personality disorder. Evidence for the diagnostic validity of dependent personality and passive personality disorders remains relatively meager.

The decision to retain histrionic personality disorder (hysterical personality disorder) is the subject of continuing controversy and has come under increasing fire from the feminist movement, which criticizes the criteria as reflecting a male definition of femininity. The stereotypic characterization of hysteria remains a source of contention, despite attempts to validate the disorder by clinical and psychological studies.

In the opinion of most clinicians and investigators, the multiaxial approach of DSM-III for the diagnosis of personality disorders represents a major advance, corresponding more to the diversity of patient characteristics occurring in clinical experience than is usually included in official diagnostic nomenclature. Nonetheless, further work on Axis II is required in order to include disturbances of personality functioning not meeting the criteria for a "disorder," but of clinical importance.

Disorders in Children

One of the first subspecialties in American psychiatry, child psychiatry arose from efforts to diagnose and evaluate children, especially delinquents involved with the juvenile justice system, to determine their physical and mental needs as well as legal disposition. The field thus began in the court and the clinic by way of the child guidance movement, pioneered by William Healey, founder and director of the Juvenile Psychopathic Institute in Chicago, the first child guidance center in the country. The public interest in child development that grew during the Progressive era and the fiscal support of the Commonwealth Fund fostered a network of child guidance demonstration clinics that developed a team approach providing psychiatric care for children and social casework for parents.

The influence of Adolf Meyer, with its emphasis on the interrelation of experience, habit and adaptation, along with the psychosexual development theories of psychoanalysis introduced in the United States in the first decades of the 20th century, provided the theoretical basis for new guidance center programs.

The current subspecialty of child psychiatry reflects, in many important ways, its early beginnings in the child guidance centers where emphasis was on the child's early experience, parental childrearing practices, the socioenvironmental influences on formation of symptoms, and psychotherapy of the child and parents as the major therapeutic intervention.

The special section in DSM-III devoted to disorders of children and adolescents includes several innovations, the most prominent being operational criteria, expansion of the multiaxial system first developed in child psychiatry by the WHO working group, and expansion of the classification by the Group for the Advancement of Psychiatry (GAP).

Agreement regarding the category of mental retardation exists among all schools of psychiatry. The DSM-III incorporates the terminology and nosology of the American Association on Mental Deficiency. Specific changes and innovative features may, however, require further refinement before acceptance of other more problematic categories occurs. In DSM-III, "minimum brain dysfunction" (MBD) and "hyperkinetic learning disability" were renamed Attentional Deficit Disorder (ADD). The validity of this disorder has been the source of much controversy, not only on scientific grounds, but also because of the possible abuse of this diagnosis among children from minority and poverty backgrounds. Moreover, there is a question as to whether these manifestations can be established as symptomatic of some defect in attention, as implied in the new term for the disorder.

A large group of conditions are grouped together as "conduct disorder." This category remains vaguely described and a subject of uncertainty, inasmuch as the major manifestations usually involve social maladjustment, most often presented in the school setting. Considerably greater specificity occurs in the area of eating disorders and the development of operational criteria for anorexia nervosa and bulimia.

A new category, "separation anxiety," groups together manifestations previously referred to as "school refusal" and "school phobia." Here, as with the attention deficit disorder, there is a presumption of an underlying psychic mechanism—in this case a special form of anxiety—for these behaviors. Diagnosis is thus made on this basis, as well as on specific behavioral manifestations. To this extent, the DSM-III deviates from its own precepts, indicating that further work in these areas is required.

Another addition—"identity disorder" in adolescence—is derived from the writings of Erikson (1968) and incorporates a widely discussed developmental concept derived from the psychoanalytic school.

The reaction of child psychiatry clinicians to DSM-III in the United States has been very mixed. In the early stages of the development of the DSM-III, the clinicians objected that the criteria emphasized descriptive psychopathology unduly and paid insufficient attention to personality dynamics and developmental processes. Despite the controversy and criticisms, however, the development of the DSM-III has provided considerable stimulus to research on diagnostic evaluations and efforts to establish the validity of many of the newer disorders, as well as to clarify the criteria for the more traditional disorders.

Advances in biological psychiatry have been slowly extended to infancy, childhood and adolescence. Most evident are those in the areas of mental retardation and the emotional states, particularly depression, and the various movement disorders. With regard to the latter group, Tourette's disorder, in particular, has been the subject of considerable research on family background and response to medication. The influence of biological research techniques is also seen in the distinction between sleepwalking disorder and sleep terror disorder, and the incorporation of research findings using sleep EEG.

The influence of developmental psychology and behavioral techniques are seen in the classification of criteria for reading disorders and related problems in language, arithmetic and other areas of learning disability. These are now incorporated in Axis II of DSM-III, which focuses on developmental disorders of childhood and adolescence.

Psychiatric Disorders of Old Age

Geriatric psychiatry has recently emerged as a subspecialty in the U.S. The quality of research and clinical practice has improved considerably, in part because of the attention focused on the increasing proportion of the population reaching old age and their impact on the health care and social services systems.

Whereas DSM-III has a special category of disorders that manifest in infancy, childhood and adolescence, no such category exists for the elderly. The major syndromes associated with aging include dementia and delirium, usually involving CNS or medical illnesses.

Syndromes of dementia and delirium and the various disorders associated with them are grouped in the DSM-III category of organic mental disorders. Among the advances in this area is the delineation of a separate category for multiinfarct dementia, representing a modification of previous thinking. In the past, many of the dementias associated with aging were attributed to generalized arteriosclerosis. It is now agreed that the cardiovascular events of thrombosis and hemorrhage resulting in infarction, rather than the diffuse vascular disease per se, contribute significantly to organic mental disorder.

Alzheimer's disease and Pick's disease, conditions previously regarded separately, are now grouped as primary degenerative dementia. This condition is often called primary dementia of the Alzheimer type.

Considerable advances in neuropathology and molecular biology have been made with regard to primary degenerative dementia. Neurofibrillary tangles have been identified as a specific neuropathologic finding, and their chemical composition is under investigation. Clinically, a tendency toward diffuse ventricular enlargement with cerebral atrophy has been documented using CAT scan techniques. Recently Position Emission Tomography (PET) has indicated a pervasive decrease in overall brain activity in patients with Alzheimer's disease as well as a general correlation between the severity of cognitive impairment with reduction in brain functioning. Whether or not CAT scan and PET scan techniques will become sufficiently established to become routine diagnostic procedures remains uncertain.

Disorders Related to Alcohol

Although research on the psychiatric consequences of alcohol ingestion was undertaken in the late 19th century, since the 1930s, with the end of Prohibition, there has been longstanding tension between psychiatry and the newly emergent field of alcoholism. American psychiatry in the

first half of the 20th century paid relatively little attention to alcoholism. Psychoanalytically oriented approaches had interpreted alcohol abuse and resultant medical and psychiatric problems as behavioral consequences of pervasive antecedent personality disorders, drawing attention to personality features such as latent homosexuality, dependency, passivity, orality and inability to tolerate anxiety, depression and frustration. These personality formulations have generated negative reactions among many alcoholic patients and those in the alcoholism organizations such as Alcoholics Anonymous (AA) and the National Council on Alcoholism (NCA).

The DSM-III diagnostic nomenclature incorporates the recommendation of numerous WHO committees that have proposed the term "alcohol dependency" in place of imprecise terms such as "addiction." The concept of "alcohol dependence" represents extension into the field of alcoholism concepts originally developed with regard to drug abuse. In DSM-III, alcohol dependence is differentiated from "alcohol abuse," the latter being characterized by excessive use of alcohol with associated social, psychological and health impairments. Epidemiologic studies have indicated a high prevalence of both alcohol dependence and alcohol abuse in the United States and have identified important risk factors in modes of use and abuse by sex, age and social background.

Recent research in biological psychiatry has emphasized the role of genetic and familial factors. In their Danish study, D. Goodwin and associates (1976) employed cross-rearing techniques to disentangle genetic from environmental influences on the adopted offspring of alcoholic patients identified through the Danish case registry. They interpret the findings as suggesting a strong genetic influence.

In a parallel fashion, Winokur and associates (1970) have drawn attention to the high co-morbidity of alcoholism and depression, and suggested possible common predisposition. The co-morbidity of alcoholism and depression has been noted in clinical settings, particularly since the application of standardized interview techniques such as the SADS, DIS and standardized diagnostic criteria such as the RDC and DSM-III. The high ratio of males to females among alcoholics is attributed in some interpersonal and social psychiatric circles to the social channeling of subclinical depressive/dysphoric features. The hypothesis is that men treat their dysphoric symptoms with alcohol, and that alcoholism abuse and alcohol dependence may mask an underlying affective illness. Women, on the other hand, more frequently manifest depressive or dysphoric symptoms with less coexistence of alcoholism, and are thus diagnosed as psychiatrically ill earlier in the course of their affective illness.

An association between bipolar illness and alcoholism has also gained increasing attention (Winokur et al., 1969). A number of clinical

trials with lithium are underway for alcoholic patients as well as for alcoholic patients with coexistent affective illness (Goodwin et al., 1969).

The standardized diagnostic approaches used with samples of patients in treatment for alcoholism indicate a considerable co-morbidity of alcohol problems and other mental disorders. Attention has been drawn to the coexistence of not only alcoholism and affective disorders, but also to the coexistence of alcohol dependence or abuse with anxiety disorders and antisocial personality.

Several risk factors associated with alcoholism have received attention from social psychiatric and interpersonal schools. In addition to the sex differences previously noted, the role of intrafamilial dynamics in early childhood and in adulthood has been emphasized. Numerous cultural and psychosocial factors have also been identified to explain the observed differences in prevalence of alcoholism among various ethnic groups. The influence of social and cultural values and family interaction patterns have been investigated to account for variations in rates among different ethnic groups.

The interpersonal school has drawn attention to the role of intrafamilial dynamics in perpetuating alcoholic behavior. The special burden of the illness on spouses of alcoholics, particularly wives, and on children have been the focus of concern in the alcoholism community, particularly through Alanon.

The behavioral school has been mainly involved in the development of therapeutic interventions based upon conditioning paradigms. The use of antabuse and aversive conditioning with drugs, such as Emetine, represent a combination of pharmacologic and conditioning approaches to treatment.

Drug Abuse

Concern for the adverse psychiatric consequences of drugs emerged in the U.S. during the mid 19th century after the Civil War. Two developments contributed to that concern: the innovation of the hypodermic syringe and the introduction of morphine.

By the end of the 19th century, the clinical features of addiction were identified: increasing dose requirements, psychological craving and dependence, and withdrawal syndrome upon cessation of use. Public concern over the adverse effects of the opiates and other narcotics resulted in the enactment of the Harrison Act in 1908. Soon afterward, there was widespread debate about heroin and other opium derivatives. The U.S. Public Health Service developed a research unit for addiction in Lexington, Kentucky, after World War II, which undertook

major research on the pharmacology of narcotic drugs and the clinical manifestations of their use. This unit is now located in Baltimore, Maryland.

Between World Wars I and II, interest extended to other classes of drugs, including marijuana, barbiturates and amphetamines. Concern accelerated after World War II over the rapid expansion of the use of heroin, amphetamines and marijuana as well as the new synthetic hallucinogens, LSD and PCP. These concerns were reflected in increasing scientific research, the creation by Congress of the National Institute on Drug Abuse (NIDA), and controversy surrounding the social, legal and treatment aspects of drug abuse. The "amotivational syndrome" described by a number of clinicians has not been completely validated and remains another source of controversy.

This section has reviewed the current state of research and theory in selected diagnostic groups. For each disorder, the approach to diagnosis and related research activities has been discussed in terms of the foci of the major schools. The framework for discussion has been predominantly, but not exclusively, the classification embodied in DSM-III.

VI. Conclusions

Heinz Lehmann's observation in 1970 that North American psychiatry was on the verge of a revival of interest in diagnosis has proven prophetic. The 1970s witnessed a series of major developments in clinical psychopathology leading to the reaffirmation of the concepts of discrete disorders and of the importance for research, training and clinical practice of reliable and well-validated criteria for diagnosis and classification.

The current period is one of considerable activity in the area of diagnosis and classification in relation to psychopathology. Operational criteria, improved techniques for developing reliability and clarification of the nature of validity, which were crystallized in the development of the DSM-III, have diffused rapidly throughout the research community and into the clinical community as well.

The schools of American psychiatry have reacted to these developments with varying degrees of involvement. The greatest acceptance has been by the biological school because of the application of these concepts toward understanding the actions of the new psychopharmacologic agents. The social psychiatry school has rapidly incorporated these diagnostic techniques in new and important epidemiologic studies attempting to determine the incidence and prevalence of psychiatric disorders, as well as to ascertain psychosocial, familial and biological

risk factors. These new techniques and concepts slowly are being incorporated in behavioral, interpersonal and psychoanalytical research and practice.

Agreement is widespread concerning the heuristic value of defining clinical syndromes on the basis of descriptive psychopathological criteria. At the same time, dissatisfaction exists regarding exclusive reliance on the symptomatic approach to diagnosis. Most investigators share the ideal of validating diagnosis by etiology. This aim is most evident in the search for biological factors which may be etiologic, but is also seen in the search for behavioral, childhood experience, personality and other nonbiological antecedents. It is now widely recognized, however, that in the past premature closure on presumed etiological factors contributed to confusion and unreliability.

While there is recognition that the availability of operational criteria has improved reliability and clarified many problems, a number of issues remain unresolved. These include the overlap between affective states and schizophrenia, including the unsettled status of schizo-affective states; the best manner in which to subdivide affective disorders; and the cross-diagnosis of alcoholism and drug abuse, on the one hand, and, on the other hand, the diagnostic relation between alcoholism and/or drug abuse and other psychiatric syndromes. In the areas of clinical care and research, efforts are underway to find laboratory and other nonclinical procedures to supplement clinical diagnostic criteria.

The most difficult problems, however, are with the personality disorders and developmental states included in Axis II, where the research challenge is to clarify the relationship between dimensional and typological approaches. Still unsettled is the basic issue of whether personality disorders represent discrete categories defined by typological criterion, or, rather, points of distribution on dimensional criteria. Considerable efforts are underway in this area, particularly research to validate disorders such as narcissistic and borderline personality disorders, as well as traditional personality disorders that have been fully validated, such as passive-aggressive personality disorder.

Even with these unsolved problems, efforts in the United States focused on issues of psychiatric diagnosis, nosology and classification evince considerable theoretical and conceptual ferment and a high level of research activity. There is an air of optimism and hope that new and developing approaches in the field will contribute to resolving issues of long-standing uncertainty and controversy.

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5
A Brief History of Psychiatric Classification in Britain

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Historical Background

17th and 18th Centuries

The historical origins of the diagnostic concepts of British psychiatrists are difficult to define with any clarity. They are woven into the history and prehistory of psychiatry and have much in common with those of the French and German schools, particularly with the former. Although classifications of disease in which different varieties of madness figured prominently were developed in the 17th century by Robert Burton and Thomas Willis, both were essentially Galenical, and in neither case does the author's reputation rest on the classification or the diagnostic concepts they introduced. The first, and perhaps the only, British classification to achieve worldwide influence was that of the Edinburgh physician William Cullen. His *Synopsis and Nosology*, published in 1769, was an elaborate and grandiose attempt to classify illness according to the Linnaean principle of classes, orders, genera and species. It is to him that we owe the term neurosis, introduced as a generic title for all mental disorders. Cullen assigned the second class of his classification to these neuroses, subdivided into 4 orders, 27 genera and over 100 species, and including a large group of "vesaniae," paranoid illnesses he described in detail in a later book, *First Lines of the Practice of Physik*. His classification owed its inspiration and much of its reputation to the earlier work of the botanist physicians, Boissier de Sauvages and Carl von Linné, and it was not long before its complexity and pretentions provoked a sceptical reaction. In 1782, Thomas Arnold poured scorn on Cullen and his fellow "botanical nosologists" and insisted that there

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was only one genus of mental illness, that of insanity, and only two forms of insanity, ideal and notional.

19th Century

The conflict between complexity and simplicity exemplified by this dispute persisted throughout the 19th century largely because, in the absence of any agreed corpus of knowledge about the causes of madness or any specific treatments, the matter was not susceptible to resolution. One man's opinion was as good as another's, and as a result many asylums had private classifications of their own, reflecting the personal views of the physician superintendent. David Skae, for example, recognized 27 varieties of insanity, mostly of his own invention. His classification was used by a number of his friends and pupils, but when Clouston, his successor at the Edinburgh Royal Asylum, urged its more general adoption, it was rejected out of hand by Crichton Browne (Chrichton Browne, 1875) as being "philosophically unsound, scientifically inaccurate and practically useless."

Throughout the 19th century, most theoretical or conceptual—as opposed to administrative or therapeutic—innovations were derived from French or German writers: Pinel, Esquirol and Heinroth in the first half of the century; Wernicke, Morel and Charcot in the second. The one important diagnostic concept to be introduced by a British alienist in that era was Prichard's moral insanity—"a morbid perversion of the feelings, affections and active powers, without any illusion or erroneous conviction impressed upon the understanding," which "sometimes coexists with an unimpaired state of the intellectual faculties" (Prichard, 1835). This novel extension of the boundaries of insanity led to the now defunct legal concepts of the moral imbecile (1913) and moral defective (1927), and ultimately to the concept of the antisocial psychopath.

If British psychiatry had a distinctive theoretical orientation at this time it was one of pragmatism, reflecting the managerial needs and attitudes of the asylum officers of the day. In the main their preference was for simple groupings based on symptoms, course and other readily observable phenomena, and they tended to distrust elaboration and complexity, particularly elaborate classifications based on exciting but unproven speculations about etiology. It was the fanciful etiological assumptions on which it was based that made Skae's classification unacceptable to Crichton Browne. Although he accepted the ultimate desirability of an etiological classification he was convinced the time was not yet ripe. "We are still as far as ever from mounting a delusion in Canada balsam, or from detecting despondency in a test-tube," he

remarked, and that being so, the simple behavioural classification of Esquirol was preferable to more elaborate and pretentious alternatives (Crichton Browne, 1875). This attitude was shared by Henry Maudsley, the dominant intellect of the day. In the 3rd edition of his *Pathology of Mind* (1879), he defended his preference for a simple symptom-based classification as follows:

> This necessity of calling up by a general term the conception of a certain co-existence and sequence of symptoms is a reason why the old classification holds its ground against classifications that are alleged to be more scientific; it is good as far as it goes, but it by no means goes to the root of the matter; whereas the classifications which pretend to go to the root of the matter go beyond what knowledge warrants and are radically faulty.

In the 1895 edition he was even more explicit:

> I have purposely avoided mention of the numerous and elaborate classifications which, in almost distracting succession, have been formally proposed as exhaustive and tacitly condemned as useless. For the same reason I have shunned the use of the many learned names—of Greek, Latin and GraecoLatin derivation—which have been invented in appalling numbers often to denote simple things and sometimes, it may be feared, with the effect of confounding apprehension of them. Insanities are not really so different from sanities that they need a new and a special language to describe them; nor are they so separated from other nervous disorders by lines of demarcation as to render it wise to distinguish every feature of them by a special technical nomenclature.

The first attempt to introduce a uniform classification of mental disorders throughout the country was made by the Statistical Committee of the Royal Medico-Psychological Association in 1881 (Statistical Committee of the Medico-Psychological Association, 1882). It was a simple classification consisting of congenital mental deficiency (with or without epilepsy), acquired epilepsy, general paralysis of the insane, four types of dementia, five of melancholia and six of mania. Its authors expressed the modest hope that even if "some Superintendents will prefer not to follow the subclasses it is hoped that all will be willing to adopt the primary classes, and that uniformity of classification will to this extent be attained." They were quickly disillusioned. Despite the efforts of their energetic and influential chairman, Hack Tuke, and a series of revisions in 1904, 1905 and 1906, most of the Association's members continued to use their own private classifications, and the attempt to achieve uniformity was finally abandoned when the radically new concepts introduced by Kraepelin and Bleuler threw everything into a state of flux. An almost identical sequence of events took place in the United States of America.

1900—1950

For the first three decades of the 20th century there were few theoretical developments of any importance in British psychiatry. Kraepelin's concepts of manic-depressive insanity and dementia praecox were accepted fairly quickly, and the prestige of the German university clinics increased steadily. But although Bleuler's term, schizophrenia, eventually displaced Kraepelin's dementia praecox, his etiological assumptions never became so influential as they did in North America. The same was true of the influence of the Viennese school of psychoanalysis. Although Freud's writings were well known and much discussed, the psychoanalytic movement never developed the widespread influence on British psychiatry that it had in the USA in the 1940s and 1950s. Psychoanalytic clinics flourished in London, particularly after the arrival of Freud himself and his daughter Anna, but they never became a dominant influence within the walls of the mental hospitals or in the new university departments of psychiatry. And despite an increasingly close political relationship with France contact with French ideas was lost almost completely after Janet's day.

A more distinctive British school of psychiatry, and with it a distinctive attitude to classification, began to emerge in the 1930s. The Maudsley Hospital, the embodiment of Henry Maudsley's vision of a university psychiatric clinic on the German model, had opened in 1919, and the University of Edinburgh had established a chair of psychiatry in the same year. Other small university departments of psychiatry started to be created from that time on. These embryonic departments were greatly strengthened by an influx of distinguished German and Austrian refugees in the late 1930s, notably Mayer Gross and Guttman from Heidelberg and Stengel from Vienna. Another crucial influence was that of Adolph Meyer, for several of the most influential teachers of that generation, including Aubrey Lewis at the Maudsley Hospital and David Henderson in Edinburgh, had been his pupils in Baltimore and had brought his distinctive holistic views back to Europe with them. These, then, were the predominant influences as British psychiatry began to expand its influence after the Second World War—the German academic tradition, particularly that of the Heidelberg school; a distrust of elaborate theoretical formulations inherited from Henry Maudsley and other 19th century alienists, and Adolph Meyer. To these were added the scholarship, skepticism and emphasis on empirical evidence of Aubrey Lewis and the new Institute of Psychiatry at the Maudsley hospital. The experience of treating and rehabilitating the psychiatric casualties of war, the psychoanalytic movement and changing public attitudes to mental illness were other important influences, but their main effect was on the milieu of mental hospitals and the

development of new social and psychological forms of treatment rather than on diagnostic concepts and attitudes to classification.

After the abandonment of the Royal Medico-Psychological Association's attempt to introduce a uniform national classification at the end of the 19th century, the main influence on diagnostic concepts was exerted by influential teachers, particularly through their textbooks. In the 1940s and 1950s Henderson and Gillespie's textbook was pre-eminent, and as a result the concept of involutional melancholia and Henderson's rather muddled ideas on psychopathy both gained wide currency. The publication of Mayer Gross' textbook in 1954, however, resulted in a new emphasis on the importance of diagnostic distinctions between endogenous and reactive illnesses, and on the constitutional and genetic rather than the psychological and social determinants of psychiatric illness.

British Psychiatry and the International Classification

Soon after its formal creation in 1948, the WHO produced a 6th revision of the International Statistical Classification of Diseases, Injuries and Causes of Death. This was more important than it sounds because previous editions had been concerned only with causes of death, whereas this 1948 revision was for the first time a comprehensive nosology covering the whole range of disease—and so included a classification of mental illness. In fact, Section V of ICD-6, entitled Mental, Psychoneurotic and Personality Disorders, contained 10 categories of psychosis, 9 of psychoneurosis and 7 of "disorders of character, behaviour and intelligence," most of them subdivided further. This classification was adopted for official use in the United Kingdom, and since that time the successive editions of the International Classification have been used by the Ministry of Health and its successor, the Department of Health and Social Security, in all official documents and in its statistical analyses of admissions to mental hospitals and other psychiatric inpatient units. This is not to say, however, that either ICD-6 or its successors have been widely used by British psychiatrists. Whether or not they were even aware of the existence of the International Classification, and in the 1950s many were not, most psychiatrists continued to use whatever diagnostic terms they thought fit, and the clerks and statisticians engaged in the compilation of statistical returns had to convert these into the official nomenclature as best they could.

Unsatisfactory as this state of affairs was, from the point of view of the WHO it was less serious than that in most other countries. Al-

though the nomenclature of ICD-6 had been unanimously adopted by the 1948 revision conference and duly "recommended for use" by all Member States, only five countries had ever adopted the Mental Disorders section of the classification, the others being Finland, New Zealand, Peru and Thailand.

In 1958, the WHO asked Erwin Stengel to investigate the situation worldwide and if possible to make recommendations. His report is an impressive document (Stengel, 1959). The situation he encountered he described as one of "almost general dissatisfaction with the state of psychiatric classification, national and international," and the attitude of many psychiatrists toward classification, at least in its conventional forms, seemed to have become "one of ambivalence, if not cynicism." Stengel was convinced that the most important reason for the inability, or refusal, of psychiatrists to agree to use a common nomenclature, national or international, lay in the etiological implications of diagnostic terms, and that it was the objections of different schools of psychiatry to each other's assumptions about etiology that lay at the root of the problem. His answer to this problem, and his most important recommendation, was that all diagnoses should be explicitly shorn of their etiological implications and regarded simply as "operational definitions" for certain specified types of abnormal behaviour. He also recommended that in future revisions of the International Classification the nomenclature should be accompanied by a companion glossary "available from the beginning in as many languages as possible."

Spurred on by this report and the chaotic situation it revealed, the WHO and its Expert Committee on Mental Health made strenuous efforts to improve the Mental Disorders Section of the International Classification, to persuade more countries to use it and to provide a companion glossary that would facilitate its use. When it became apparent that it was going to take too long to secure agreement on the wording of an international glossary, it was decided as an interim measure to encourage individual countries to produce their own national glossaries to the nomenclature of the 8th revision. The United Kingdom responded to this invitation, as did the American Psychiatric Association, and a committee set up by the Registrar General under the chairmanship of Sir Aubrey Lewis produced a UK glossary in time for the introduction of ICD-8 (General Register Office, 1968). For the next decade this booklet had a valuable but limited role. It provided some useful guidance on the meaning and scope of the various categories of disorder recognized in ICD-8, and experience of its use paved the way for the production some years later of the International Glossary (WHO, 1974). Indeed, as Lewis was chairman of the WHO working Group responsible for this and several other British psychiatrists were also involved, several sections of the International Glossary were

derived from the UK glossary. Nevertheless, this British glossary had serious limitations. In the first place, it had the inevitable shortcomings of any purely national glossary. Some categories, like latent schizophrenia, were defined in completely different ways from the other (American) national glossary to ICD-8, and the reactive psychoses introduced into ICD-8 at the urging of Norwegian and Danish psychiatrists were described in terms that amounted to an invitation to ignore them. Secondly, and more fundamentally, none of the glossary's definitions were the operational definitions Stengel had advocated. They were thumbnail sketches describing the core of the concept in question tolerably well, but they gave little guidance on where its boundaries lay or what minimum criteria had to be met before the diagnosis was made. But perhaps most important of all, the glossary had little impact on the diagnostic practice of the majority of British psychiatrists. Although it was used by several groups for research purposes, a comparison of the diagnoses given to two random samples of 1000 first admissions to English mental hospitals in1968 and 1971, i.e., before and after the introduction of the new nomenclature of ICD-8 and its companion glossary, revealed no detectable difference between the two (Kendell, 1973). In both, over one-third of all diagnoses could not be converted into any category at all in either ICD-6 or ICD-8, and the many new terms introduced in the latter, such as transient situational disturbance and reactive psychosis, were still conspicuously absent in 1971.

This study also shed light on the diagnostic predilections of English psychiatrists working outside the main teaching centres. It revealed the same preference for broadly based clinical syndromes and the same distrust of fine distinctions and etiological assumptions that Crichton Browne and Henry Maudsley had expressed almost a century before. Over 50% of all depressive illnesses were described simply as "Depression" or "Depressive illness." The majority of personality disorders and schizophrenic illnesses were likewise described simply as "Personality Disorder" and "Schizophrenia." Indeed, the only schizophrenic subtype to be diagnosed with any frequency was paranoid schizophrenia, and many of the classical diagnoses were remarkably rare. In the entire series of 2000 diagnoses, there were only three of melancholia and four of involutional melancholia. Even the diagnosis of manic-depressive psychosis appeared only 20 times. Similarly, in the schizophrenic domain, there were only two diagnoses of catatonic schizophrenia, three of simple schizophrenia, five of hebephrenia and none at all of paranoia. Another notable characteristic, which presumably reflected a distrust of neat diagnostic boundaries, was the presence of many "half-and-half" diagnoses like "anxiety depression" and schizoaffective disorder.

Recent British Research on Classification

It is clear from the preceding discussion that in the 19th century, and for some time thereafter, classification did not interest British psychiatrists as much as their French and German counterparts. Zilboorg's wry comment that "to produce a well-ordered classification almost seemed to have become the unspoken ambition of every psychiatrist of industry and promise" was directed mainly at continental Europe. In the 1920s, however, a controversy developed in Britain over the classification of depressive illnesses which has continued ever since. Although super- ficially this controversy was and is concerned purely with depressive illnesses, it has continued so long, and so much time and energy have been devoted to it, partly at least because it serves as a convenient arena for several broader disputes about the nature and classification of mental illness as a whole: whether mental illnesses are diseases or reaction types; whether they are independent entities or arbitrary concepts; whether they should be classified on the basis of their symptomatology, their etiology, their pathogenesis or a mixture of all three; and whether they are better portrayed by a topology or by dimensions.

The controversy was started in 1926 by Edward Mapother, the first professor of psychiatry at the Maudsley hospital, suggesting that the distinction between neurosis and psychosis was primarily a matter of administrative convenience, and that there were no fundamental differences between them. This heretical assertion led to a prolonged and at times rather acrimonious debate about the relationship between psychotic and neurotic depressions; one school, headed by Crichton Miller and later by Mayer Gross and his protegé Martin Roth, claimed that the two were distinct illnesses, differing in symptomatology, etiology and prognosis; the other, headed by Mapother and Lewis at the Maudsley Hospital, argued that "to set up a sharp distinction 'in the interests of academic accuracy' when the distinction is not found in nature is no help to thought or action" (Lewis, 1934). The development in the late 1950s of elaborate techniques of multivariate analysis and the computers necessary for their utilization shifted the argument to a more empirical and statistical plane. Various forms of factor analysis, discriminant function analysis and cluster analysis were enthusiastically and at times rather uncritically applied to ratings of the symptomatology of cohorts of depressed patients, but without any real change in the nature of the controversy, or any agreed outcome. It all led, however, to a better appreciation of the complexity of the relationship between symptomatology, life events, treatment response and long-term course, and also to a clearer understanding of the crucial need for representative samples of patients and reliable clinical ratings.

This increasing awareness of the vital importance of reliable ratings of symptomatology led to the development of structured interviewing methods. In the USA the lead was taken by Joseph Zubin's Biometrics Research Unit in New York whose *Mental Status Schedule* and its successor the *Psychiatric Status Schedule* stipulated the precise wording and the sequence of every question the patient was asked. In Britain, the initiative was taken by the Medical Research Council's Social Psychiatry Unit at the Maudsley Hospital, and that unit's interest in psychotic illness led to the development of a semi-structured interview that allowed the interviewer significantly more freedom and flexibility. The *Present State Examination* developed by John Wing and his colleagues in the late 1960s struck the right balance between rigidity and flexibility and was also sufficiently comprehensive to cover the whole range of functional illness (Wing et al., 1974). It was therefore well suited to the study of psychotic symptomatology and was soon used extensively both in Britain and further afield. Indeed, it became the main clinical instrument in the International Pilot Study of Schizophrenia and also in the US/UK Diagnostic Project. The primary purpose of the latter was to investigate the major differences—of up to 20-fold in some age groups—in hospital first-admission rates for schizophrenia and manic depressive illness between the USA and England and Wales. Representative samples of patients were examined in New York and London using the *Present State Examination* and other structured interviewing methods and the same diagnostic criteria applied to both (Cooper et al. 1972). In the event the huge differences in observed admission rates in the two countries proved to be due entirely to differences in diagnostic criteria, American psychiatrists having a much broader concept of schizophrenia than their British counterparts and a correspondingly more restricted concept of manic depressive illness. Although in a sense this was a disappointing finding, because it put an end to several interesting speculations about why schizophrenia should be commoner in America than in Britain, it did have the salutary effect of convincing all concerned of the overriding need for uniform and reliable diagnostic criteria. The project also generated a large volume of reliable clinical ratings of representative samples of psychiatric inpatients, and these ratings were used for a number of subsidiary studies—of the relationships between schizophrenic and affective psychoses and between psychotic and neurotic depressions, and of the prognostic validity of different operational definitions of schizophrenia. Members of the project team also carried out relatively small-scale studies of variation in diagnostic criteria within the British Isles; of differences in the diagnostic criteria of German, French and British psychiatrists; and of the types of information used in the decision-making process leading to a clinical diagnosis.

In the 1950s a serious interest began to be taken for the first time in the psychiatric disorders of old age, prompted of course by their increasing clinical importance. In an influential pioneer study Martin Roth showed that there were major and stable differences in prognosis between the dementias, the confusional states and the functional psychoses of the senium, thus validating these three broad diagnostic categories (Roth, 1955). Other work by Roth and Felix Post explored the relationships between the paranoid illnesses of old age and paranoid schizophrenia, between cerebral arteriosclerosis and depression, and between the depressions of old and middle age. Among other things this led to general agreement that involutional melancholia was not the discrete entity an earlier generation had thought it to be, and that mild intellectual impairment in an elderly person with depressive symptoms did not necessarily predict progressive dementia.

At the other end of the scale, the emerging specialty of child psychiatry was attempting to develop a classification of childhood disorders. A WHO working party in 1967 agreed to experiment with a novel triaxial classification, and Rutter subsequently organized a formal comparison of this new multiaxial classification and the existing ICD-8 groupings. (Rutter et al., 1975). Although the reliability of ratings on its psychosocial stress axis was low, this new multiaxial classification proved superior to the uniaxial format of ICD-8 in most other respects. The clinical syndromes it recognized were more appropriate, it was better at handling psychiatric disorders associated with mental retardation and physical illness, and it was preferred by the clinicians participating in the study.

Conclusion

In summary, although British psychiatrists took less interest in classification than their French and German counterparts in the 19th century, they have taken a steadily increasing interest from the 1930s onwards. This culminated in some substantial and productive research in the 1960s and early 1970s. Since that time, however, interest in classification has tended to wane, in contrast to the USA. This is partly because research funds are now less freely available, but partly also because classification is no longer seen as an exciting and potentially rewarding area for research. The main lessons of the 1970s—the need for structured interviewing methods and the importance of operational criteria for diagnostic and other technical terms—have been well learnt, but the main focus of interest has now shifted to a new series of attempts to

unravel the biological and social factors involved in the etiology of psychiatric disorders.

British psychiatry does not have, and indeed never has had, any important diagnostic concepts of its own in the way that French, American and Scandinavian psychiatry still do. There are several reasons for this. The United Kingdom has been committed to using the International Classification for longer than most other countries. Moreover, several British psychiatrists have played a prominent role in the discussions that have preceded the introduction of the last three revisions of the ICD and have often acted as consultants to the WHO. As a result, the format of the ICD has been influenced in many ways by our views and prejudices. On the other hand, our most important national prejudice—a preference for a simple classification based on a small number of major syndromes—has been consistently thwarted by the need of the WHO to secure the agreement of as many countries as possible to the nomenclature of the ICD. Because it is always more important to individual national representatives to ensure the inclusion of their own familiar diagnostic categories than it is to exclude other terms they do not wish to use, any international nomenclature has an innate tendency to expand. This is well exemplified by the variety of depressive illnesses recognized in successive revisions of the international classification. In ICD-6 and ICD-7 there were three varieties, in ICD-8 there were four and in ICD-9 there were no less than ten—even though much research in the interim had failed to validate even the primary subdivision into psychotic and neurotic depressions.

Since 1980 attitudes to classification have been dominated by the American Psychiatric Association's innovatory classification, DSM-III (APA, 1980). As in the United States there has been a clear divergence of views. The younger generation has welcomed the operational definitions, multiple axes and novel format of this nomenclature, while some of their elders have remained skeptical of the value of inflexible definitions to experienced clinicians like themselves, and have also been affronted by the elimination of hallowed terms like hysteria, neurosis and manic-depressive psychosis. Despite widespread acceptance of its basic principles, however, DSM-III has probably been used less in Britain either for research or for everyday clinical purposes than in most other English-speaking countries. This is partly because of a sense of commitment to the principle of an international classification, partly because home grown classificatory systems like Wing's CATEGO program were already available to most research workers, and partly also because earlier American criteria like the Research Diagnostic Criteria of Spitzer, Endicott and Robins (1978) seemed preferable for many purposes. It seems certain, though, that ICD-10 will be welcomed and widely used when it is finally published in 1990, even

though the need to obtain the approval of psychiatrists from many divergent cultural backgrounds has already complicated the relatively simple format and nomenclature proposed by the original architects. The ICD-10 is firmly based on symptomatology, avoids premature assumptions about aetiology, recognizes the overriding importance of reliability and is therefore likely to be capable of serving as an effective international lingua franca, at least until the end of this century.

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6

Diagnostic and Classification Tradition of Mental Disorders in the 20th Century in Scandinavia

P. Bech*

The development of the national classification systems in the Scandinavian countries in this century is shown in Table 1. In Finland, the International Classification of Diseases (ICD) was adopted in 1936 (ICD-4, ISI, 1929). Since 1952, the revisions of ICD by the World Health Organization (WHO) have been in use in Finland. The other Scandinavian countries adopted ICD-8 in 1967 upon its release (WHO, 1967). In 1987, Finland, Norway and Sweden adopted ICD-9 (WHO, 1978), whereas Denmark still uses ICD-8.

Table 1. Official classification systems of mental disorders in Scandinavia.

DENMARK	NORWAY	SWEDEN	FINLAND
Danish Psychiatric Association (1938)	Minister of Health (1894)		Institute of Medicine (1923)
			ICD-4 (ISI, 1929) from 1936
Danish Psychiatric Association (1952)	Minister of Health (1926)		ICD-5 (ISI, 1938)
ICD-8 (WHO, 1967)	ICD-8 (WHO, 1967)	ICD-8 (WHO, 1967)	ICD-6 (WHO, 1948) from 1952
	ICD-9 (WHO, 1978) from 1987	ICD-9 (WHO, 1978) from 1987	ICD-7 (WHO, 1955)
			ICD-8 (WHO, 1967)
			ICD-9 (WHO, 1978) from 1987

In the following, the Danish diagnostic tradition will be described in more detail. However, the diagnostic tradition in the other Scandinavian countries has been very similar to the Danish. It is of interest

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This volume gives an overview of the origins and current state of the principles, concepts, traditions of diagnosis, and classification of psychiatric disorders throughout the world. The views held on these matters by the various schools of psychiatry are described in detail in a series of reports on the French, Russian, American, British, German, Scandinavian, Spanish and Third-World psychiatric traditions.

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